MEDICARE ADVANTAGE: WHAT BENEFICIARIES SHOULD EXPECT UNDER THE PRESIDENT'S HEALTHCARE PLAN

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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WITNESSES

SUBMITTED MATERIAL

MEDICARE ADVANTAGE: WHAT BENEFICIARIES SHOULD EXPECT UNDER THE PRESIDENT'S HEALTHCARE PLAN

WEDNESDAY, DECEMBER 4, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Murphy, Blackburn, Gingrey, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Barton, Upton (ex officio), Pallone, Dingell, Engel, Schakowsky, Matheson, Green, Barrow, Christensen, Castor, Sarbanes, and Waxman (ex officio).

Staff present: Sean Bonyun, Communications Director; Noelle Clemente, Press Secretary; Sydne Harwick, Legislative Clerk; Robert Horne, Professional Staff Member, Health; Katie Novaria, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Chris Sarley, Policy Coordinator, Environment and the Economy; Heidi Stirrup, Policy Coordinator, Health; Tom Wilbur, Digital Media Advisor; Ziky Ababiya, Democratic Staff Assistant; Phil Barnett, Democratic Staff Director; Amy Hall, Democratic Senior Professional Staff Member; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Nelson, Democratic Deputy Staff Director, Health; and Rachel Sher, Democratic Senior Counsel.

Mr. PITTS. The subcommittee will come to order. The Chair will recognize himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

The Medicare Advantage—MA—program, an alternative to the original Medicare fee-for-service—FFS—program, provides healthcare coverage to Medicare beneficiaries through private health plans offered by organizations under contract with the Centers for Medicare and Medicaid Services—CMS. MA plans may offer additional benefits not provided under Medicare FFS, such as reduced cost sharing, or vision and dental coverage. They also generally have a high rate of satisfaction, and approximately 28 per-

cent of Medicare beneficiaries have chosen to participate in Medicare Advantage.

The Affordable Care Act—ACA—as noted in a July 24, 2012, Congressional Budget Office—CBO—report, cut $716 billion from Medicare, including $308 billion from Medicare Advantage alone.

In April of 2010, the Medicare Actuary projected that these payment cuts would result in an enrollment decrease in the MA program of as much as 50 percent.

The ACA also required CMS, effective January 1, 2012, to provide quality bonus payments to MA plans that achieve four, four and half, and five stars on a five-star quality rating system developed by CMS. Rather than implement the bonus structure laid out in the law, which would have led to these cuts going into effect in 2012, CMS announced in November 2010 that it would conduct a nationwide demonstration—the MA Quality Bonus Payment Demonstration—from 2012 through 2014 to test an alternative method for calculating and awarding bonuses.

The Government Accountability Office—the GAO—in response to a request by Senator Orrin Hatch, noted that the demonstration project's design made "it unlikely that the demonstration will produce meaningful results" and recommended that HHS cancel the demonstration. GAO also stated: "We remain concerned about the agency's legal authority to undertake the demonstration."

With a price tag of $8.35 billion over 10 years, the Medicare Actuary noted that this demonstration would offset more than one-third of the reduction in MA payments projected to occur under ACA from 2012 to 2014, effectively masking the first wave of ACA-mandated cuts until next year.

A recent report by the Kaiser Family Foundation warned that more than half a million beneficiaries may have to switch to another MA plan or return to fee-for-service Medicare in 2014 as a result of the ACA.

In addition to plan availability, questions are now being raised about the possibility of rising costs and limited provider networks in the future as more ACA-mandated cuts go into effect.

I would like to thank our witnesses for being here today, and I look forward to their testimony regarding how the ACA will impact the Medicare Advantage program.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

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Mr. PITTS. Thank you, and I yield the remainder of my time to Representative Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for the recognition. I always want to thank the chairman for calling the hearing this morning.

You know, we see the headlines and we see everything that is going wrong in health care, but sometimes we forget that there are some things that actually are going OK and there are things that this committee and previous Congresses have worked on to fix, and that is one of the things we are going to be discussing this morning, but sometimes we are so busy triaging, we don't allow ourselves the luxury of examining those things that are actually working as intended.

In my opinion, Medicare Advantage is working, and it is important to hold hearings like this to learn from those successes and see where we can build upon those successes and where the potential threats that are undermining the benefits and services that now over 25 percent of seniors are experiencing and how those maybe threatened.

Medicare Advantage allows integrated care coordination that this committee has sought to bring into fee-for-service Medicare. Medicaid Advantage plans in Texas are lowering costs. They are bringing greater disease management and care coordination to patients' lives. They are encouraging wellness activities and actually using physicians to the maximum ability of their license rather than always referring to a specialist. There are those conditions that can be satisfactorily managed by a general internist or family practice physician, and we ought to encourage that and not punish it. But as money is taking out of the system and plans have been forced to restrain networks and eliminate services that made them such a good deal for seniors, we have to keep a watchful eye.

We are all hearing about people wanting to be able to keep their doctors. Well, the cuts in the Affordable Care Act pose a real danger to seniors keeping their doctors and the benefits that they now have in Medicare Advantage. The harm of these cuts is compounded when the money is not reinvested in the Medicare program. We have heard that before. You can't doubly count the money that you take out of Medicare and then count that again as a savings when you are not reinvesting the money in Part A or Part B.

One small change that has been bipartisan, Mr. Gonzalez, who used to be part of this committee, when he was on the committee offered a bill that would allow seniors to switch plans between MA plans in the first three months of the year right after the open enrollment period. That was a reasonable suggestion of his at the time, and one that I think the committee could support.

Mr. Chairman, I had some time to go through the archives, and I encountered a very brilliant and insightful opinion piece that was printed in the Washington Times June 16, 2012, and I would like to offer it for the record.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

EDITORS' PICKS: Angry NTSB ousts railroad union from N.Y. train crash site

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BURGESS: Medicare-less

Patients will have fewer options under Obamacare

COMMENTS (8) SIZE: + / - PRINT

By Rep. Michael C. Burgess Wednesday, June 6, 2012

When it comes to medical care, patients - not bureaucrats - know best what works best for them. While that sounds obvious to most Americans, in Washington, unfortunately, it's uncommon wisdom.

Medicare Advantage was first created as an alternative option to the Medicare fee-for-service program allowing patients the choice to enroll in a private-sector health (#) plan. It now amounts to as much as 28 percent of the Medicare market, roughly $150billion per year. These plans, which usually have out-of-pocket maximums of $6,700 per year to protect beneficiaries from catastrophic medical expenses, serve as a lifeline for millions of American seniors.

Unfortunately, by 2014, when Obamacare goes into effect, the program will be unrecognizable. The new rules will give health insurers (#) a financial incentive to chase arbitrary targets from years before, instead of simply providing Americans with high-quality, affordable care. Because it is dated and ignores the beneficiaries, the information the federal government will provide regarding Medicare Advantage programs will be fundamentally misleading.

Since 2008, Medicare Advantage plans have been graded from one to five stars, with plans rated four stars or greater being eligible for bonus payments from the government. Competition for enrollees plus bonuses for stars are incentives for better performance. It sounds good, right? That's not how it's been implemented.

They crunched numbers for cancer and cholesterol screenings for 2010, and flu vaccinations for February through June 2011 - excluding peak flu season (#) in the fall - and applied a complex combination of 34 other measures over six different time periods, all ending three months before the insurance companies had any idea what yardsticks the government was using to measure them.

About the only thing they left out is where to use the divining rod.

If that all sounds more like witchcraft than modern medicine, it's because it is. In fact, by the time the government issues its criteria for grading the stars plans, insurers would be already past the date at which they can change their plans for the following year.

In 2013, the year before Obamacare goes into effect, Medicare Advantage beneficiaries will find themselves in stars plans based on statistics from 2010 - numbers which were already out of date before the law even passed.

The saddest irony is that under Obamacare, less than half of America's poor will have access to a

four-star plan to begin with. And wasn't providing them with good health care ☞(#) the whole point of the law in the first place? Isn't that why Congress called it the Affordable Care Act?

Highly rated plans skew heavily in favor of whiter and wealthier populations. In 2012, Medicare Advantage plans rated four stars or higher are available for 50.9 percent of eligible beneficiaries, in 32.9 percent of all counties. But for counties with poverty rates of 25 percent or higher - the poorest 9.3 percent of counties - only 13.4 percent of beneficiaries have access to four-star plans.

In other words, under Obamacare, the poor, minorities and seniors on tight budgets will face even greater impediments to purchasing good health care plans. Because the stars system will encourage insurance companies ☞(#) to provide only plans that earn four or five stars, and eventually scrap the rest, those people may lose their Medicare Advantage option.

Government works best when it creates fair and sensible rules, and allows companies to compete to deliver quality goods. The rules should be predictable, and they should encourage insurance ☞(#) companies to improve care results in the eyes of the patients themselves, not based on nonsensical Washington yardsticks.

The Medicare Advantage market so many seniors have come to rely on came closer to that before Obamacare became law, but it's still possible to make it more competitive today.

The purpose of the stars program is respectable: Encourage plans to provide higher quality care for Medicare Advantage patients.

If Medicare structured its incentive program in a manner that allowed Americans to choose the plans that best met their needs, it could reward companies for providing better health care to more people at a lower cost - something we should all celebrate.

Ultimately, that's not all that hard: Put choices in the hands of the patients, not the politicians.

Rep. Michael C. Burgess, a physician and Texas Republican, is chairman of the Congressional Health Care Caucus.

Mr. PITTS. The gentleman yields back, and now the Chair recognizes the ranking member of the Health Subcommittee, Mr. Pallone, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts, and thank you to our witnesses for being here to share your expertise.

Today I am pleased we have the opportunity to talk about Medicare and the positive reforms introduced by the Affordable Care Act to Medicare Advantage. While the majority of Medicare's 52 million beneficiaries are in the traditional Federally administered Medicare program, Medicare Advantage, or MA, offers beneficiaries an alternative option to receive their Medicare benefits through private health plans. Fifteen million people, or 29 percent of all Medicare beneficiaries, are enrolled in MA plans as of September 2013, an increase of 30 percent since 2010.

The ACA included reforms to Medicare Advantage payment policies and added a number of benefits and protections for beneficiaries both through MA and traditional Medicare. For example, Medicare must cover wellness visits and preventative services with no copayments or coinsurance. The ACA also ensures that MA plans beginning in 2014 spend at least 85 cents of every dollar received in premiums on actual care. Beneficiaries will also receive discounts through the ACA on their medications when they reach the coverage gap, or donut hole, in Medicare Part D, and these discounts will grow over the next several years until the gap is closed.

In addition, the ACA aims to improve the quality of MA plans by rewarding plans that deliver high-quality care with bonus payments. Incentivizing quality patient care over quantity of services provided is key to improving healthcare outcomes and reducing waste and the rising cost of health care.

The ACA will also bring MA payments more in line with traditional Medicare payments. On average, Medicare has been paying more per enrollee to these private MA plans than the cost of care for those on traditional Medicare. By reducing MA payments over time, there will be greater parity between MA and traditional Medicare payments, resulting in savings that will benefit enrollees and help secure the solvency of the Medicare Trust Fund for a longer period of time.

Now, critics of these payments reforms predicted that MA costs to enrollees would rise, that the provider networks and plan choices would decrease, and MA enrollment would drop. Changes in provider participation, pricing and coverage occur every year as an inherent part of insurers' business decision-making including long before the passage of the ACA, and that is why we have provided tools to CMS to ensure that seniors are protected from potential changes that private plans may make.

In addition, seniors continue to have the choice that best suits their individual health needs, and every year continue to maintain the ability to pick a new plan or traditional Medicare.

So I look forward to hearing more from our witnesses on recent trends in Medicare Advantage. I think we can all agree that our

work as a committee needs to continue beyond the improvements we made in the ACA. So your guidance today on ways we can continue to strengthen the program for our seniors is critical. We can't return to the ways before the Affordable Care Act. We must move our healthcare system to one of quality and efficiency in all of Medicare.

So thank you again, Mr. Chairman, and I yield back the balance of my time.

Mr. PITTS. The Chair thanks the gentleman, and now recognizes the chairman of the full committee, Mr. Upton, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Well, thank you, Mr. Chairman.

You know, every day we are hearing from folks and families across the country about how the President's healthcare bill has wreaked havoc on their own healthcare coverage, with millions receiving cancellation notices, millions more facing premium rate shock, and others still left to wonder if their applications on HealthCare.gov were even successful.

This morning, we are going to focus on how the health care of our Nation's seniors and disabled could be affected by the changes in the President's healthcare plan.

The President's healthcare law cut over $700 billion from the already struggling Medicare program to help fund the flawed new entitlement. Included in these cuts were over $300 billion in direct and indirect reductions to the Medicare Advantage program, and many of these cuts will start in 2014.

Medicare's managed care program, also known as Medicare Advantage, currently provides coverage for more than 14 million Americans, over a quarter of all Medicare beneficiaries, and these patients choose Medicare Advantage plans over traditional Medicare for a variety of reasons including improved cost sharing, enhanced benefits, better care coordination, and in fact, higher quality of care. For millions of Americans, especially those with lower incomes, Medicare Advantage is a better option for delivering their care, and frankly, their choice.

While Medicare Advantage continues to grow, the cuts made in the healthcare law threaten the future of the program and could put coverage at risk for thousands of beneficiaries in 2014 and many more in the future.

According to a report by the Kaiser Family Foundation, more than half a million beneficiaries may lose their existing Medicare Advantage plan next year, which would then force those seniors and disabled Americans to switch their current plan or return to a traditional fee-for-service plan. More than 100,000 beneficiaries enrolled in a Medicare Advantage plan in 2013 will not be able to enroll in a Medicare Advantage plan at all in 2014.

Likewise, for thousands of America's most vulnerable, "if you like your doctor, you will be able to keep your doctor" is sadly another broken promise. Reports confirm that many Medicare Advantage enrollees will see a change in their provider networks next year as a result of the new law. So empty promises may be of little concern

for some but they have real consequences for the Americans who expect us to do no harm. Americans deserve to know why their existing coverage is changing when they were promised otherwise, and this morning's hearing will be an important opportunity to get some answers from a number of good experts, and we appreciate you being here, and I yield to Dr. Cassidy.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Every day we hear from individuals and families across the country about how Obamacare has wreaked havoc on their healthcare coverage, with millions receiving cancellation notices, millions more facing premium rate shock, and others still left to wonder if their applications on HealthCare.gov were even successful. This morning, we will focus on how the health care of our Nation's seniors and disabled could be affected by the changes in the president's healthcare plan.

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According to a report by the Kaiser Family Foundation, more than half a million beneficiaries may lose their existing Medicare Advantage plan next year, which would force these seniors and disabled Americans to switch their current plan or return to a traditional fee-for-service plan. More than 105,000 beneficiaries enrolled in a Medicare Advantage plan in 2013 will not be able to enroll in a Medicare Advantage plan at all in 2014.

Likewise, for thousands of America's most vulnerable, "if you like your doctor, you will be able to keep your doctor" is sadly another broken promise. Reports confirm that many Medicare Advantage enrollees will see a change in their provider networks next year as a result of the new law.

Empty promises may be of little concern to this administration, but they have real consequences for the Americans who expect Washington to do no harm. Americans deserve to know why their existing coverage is changing when they were promised otherwise, and this morning's hearing will be an important opportunity to get some answers from a panel of expert witnesses.

OPENING STATEMENT OF HON. BILL CASSIDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. CASSIDY. Thank you, Mr. Chairman.

Over 37,000 of my constituents in Louisiana are enrolled in Medicare Advantage programs. MA plans offer higher quality care and additional benefits, more so than offered in traditional Medicare, and yet despite MA's popularity, MA has challenges.

The President's healthcare law cuts Medicare Advantage by over $200 billion. Now, I am a doc. When I see that the people who would come to me are having this many cuts in the programs that cover them, intuitively, common sense tells you that they will have increased problems finding a doctor, they will have higher premiums, higher copays, fewer benefits and plan choices. Even now with only 20 percent of these cuts implemented, there are reports of these problems already.

I along with Congressman Barrow and 60 other Members of Congress have signed a letter opposing other cuts to the MA program. I urge my colleagues on the committee to make the same commitment to their constituents who have come to rely upon Medicare Advantage.

With that, I yield——

Mr. SHIMKUS. Dr. Cassidy, will you yield me back the balance?

Mr. CASSIDY. I yield my time back to the chairman.

Mr. UPTON. Yield to Mr. Shimkus.

Mr. GINGREY. Mr. Chairman, did you yield to me?

I thank the chairman for yielding.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Look, Medicare Advantage has been around since, what, the late 1980s? It was Medicare Plus Choice, then it was Medicare Advantage, but the word "advantage" just means exactly what it says. It is an advantage.

You know, it is kind of interesting that the Democrats in creating this Affordable Care Act demanded that policies have minimum coverage requirements, and that this why the cost of so many of those policies has gone up and people have been notified that they are not going to be able to keep those policies January 1, 2014, because they are demanded to include so many additional things. Well, why would Medicare Advantage not cost more because they are more things in it, more provisions, preventive care, annual physical examinations, a nurse checking up, making sure that the patient got the medications filled, that they return for their appointment and timely follow up? So to gut that program—and that is what this is all about.

I am really looking forward to what the witnesses have to say about it but it made no sense to cut $300 billion out of a program that 29 percent of Medicare beneficiaries had chosen, and it has gone up over the years each and every year, and I yield back.

Mr. PITTS. The gentleman's time has expired. The Chair now recognize the ranking member emeritus, Mr. Dingell, 5 minutes for opening statement.

Mr. DINGELL. I don't have an opening statement. I am going to have some fun with my questions. Thank you, Mr. Chairman.

Mr. PITTS. The opening statements have been made by the members. I will now introduce our panel of five witnesses.

The first is Mr. Douglas Holtz-Eakin, President, the American Action Forum; Mr. Joe Baker, President, Medicare Rights Center; Dr. Bob Margolis, CEO, HealthCare Partners, and Co-Chairman of DaVita HealthCare Partners; Ms. Marsha Gold, Senior Fellow, Mathematica Policy Research; and Mr. Jon Kaplan, Senior Partner and Managing Director of the Boston Consulting Group.

Your written testimony will be made part of the record. You will have 5 minutes to summarize your testimony, and at this time, the Chair recognizes Mr. Holtz-Eakin for 5 minutes for opening statement.

STATEMENTS OF DOUGLAS HOLTZ—EAKIN, PRESIDENT, AMERICAN ACTION FORUM; JOE BAKER, PRESIDENT, MEDICARE RIGHTS CENTER; ROBERT MARGOLIS, CHIEF EXECUTIVE OFFICER, HEALTHCARE PARTNERS HOLDINGS, LLC, AND CO–CHAIRMAN, DAVITA HEALTHCARE PARTNERS, INC.; MARSHA R. GOLD, SENIOR FELLOW, MATHEMATICA POLICY RESEARCH; AND JON KAPLAN, SENIOR PARTNER AND MANAGING DIRECTOR, THE BOSTON CONSULTING GROUP

STATEMENT OF DOUGLAS HOLTZ—EAKIN

Mr. HOLTZ-EAKIN. Thank you, Chairman Pitts, Ranking Member Pallone and members of the committee for the privilege of appearing today.

Let me take this opportunity to emphasize a few points that I made in my written statement.

The first, as has been pointed out by the chairman and others in their opening statements, is that Medicare Advantage is a valuable and popular part of Medicare with nearly 30 percent of beneficiaries voluntarily enrolled in it, increasing enrollments each year, and it does provide extra services and innovative approaches to health care in the Medicare program. It disproportionately serves lower-income beneficiaries and minorities, and has been the program of choice for them, but most importantly, Medicare Advantage is not fee-for-service medicine and thus it represents an important opportunity to move away from the practice of medicine that has proven costly and that rewards volume over quality in the American healthcare system.

Unfortunately, Medicare Advantage is under a four-fold funding reduction due to provisions in the Affordable Care Act and then others more recently. The first stems from reductions in fee-for-service spending per se; the second, the modification of the Medicare Advantage bench marks relative to fee-for-service spending in each county; the third, the implications of a health insurance tax that will come online in 2014, which will affect many MA plans and further act as a pressure on the ability to provide benefits; and the fourth, the recent requirement that CMS provide changes in the coding intensity for Medicare Advantage plans.

The results of these changes are inevitable. The first will be fewer plans. Estimates range from 60 to 140 fewer plans in 2014. There are reports of 10,000 cancellation notices in Ohio, 50,000 in the State of New Jersey, and these all represent further violations of the pledge that if you like your health insurance, you can keep it under the Affordable Care Act.

In addition, there will be fewer enrollees. Projections are that there will be up to 5 million fewer enrollments by 2019 when the ACA cuts are fully implemented, and these reductions are disproportionately borne by lower-income Americans. Our estimates are that about 75 percent of the impacts hit those making less than $34,200.

The next step for those plans that do survive is to pass along these reductions in the form of either higher cost sharing or reduced benefits or more limited networks that provide beneficiaries with fewer choices. These are not the voluntary decisions of insur-

ers; these are the natural consequences of the law which limits their ability to provide options to beneficiaries.

Going forward, I would emphasize that it is very important to preserve this steppingstone to coordinated care and the better practice of medicine in Medicare and that it would be extremely undesirable for Congress to repeat the practice of using Medicare Advantage as a funding source for further expansions of other program initiatives. This is a valuable program that has proven on the ground to provide high-quality care, innovative approaches to medicine, and is the popular choice of many of the least well-off beneficiaries. Further reductions in its availability are an undesirable policy step.

I thank you, and I look forward to answering your questions.

[The prepared statement of Mr. Holtz-Eakin follows:]

Medicare Advantage:
Assessing the Impact of ACA Funding Reductions

U.S. House of Representatives
Energy and Commerce Committee
Subcommittee on Health

Douglas Holtz-Eakin, President*
American Action Forum

December 4, 2013

*The views expressed here are my own and not those of either the American Action Forum or the Partnership for the Future of Medicare. I thank Emily Egan and Christopher Holt for their assistance.

Chairman Pitts, Ranking Member Pallone and Members of the Energy and Commerce Health Subcommittee, thank you for inviting me to discuss impact of funding reductions in the Patient Protection and Affordable Care Act (ACA) on Medicare Advantage. In this testimony I seek to make three key points:

1) Medicare Advantage is a vital program that gives seniors needed options and provides value;

2) The ACA was sold to Congress and the public with a promise that those who liked their coverage could keep it. We know this is not true with regard to the private insurance market, and due to cuts in the ACA it is proving untrue for Medicare Advantage beneficiaries as well; and

3) The Medicare Advantage cuts are already having a negative impact on enrollment and seniors' plan choice. Those most hurt by the cuts are low-income seniors in rural areas without other options for supplemental Medicare coverage. Additional scheduled cuts in the future will broaden the damage to Medicare Advantage.

Background

Medicare Advantage (MA) is an option within Medicare in which beneficiaries elect to have their benefits covered by a private company. The companies then design plans that cover the standard Medicare services, or more. Depending on the plans' bids and whether prescription drug coverage is included, the MA plan may charge a small premium to enrollees above what they would pay for Part B and/or Part D coverage in traditional Medicare. Surveys indicate that the program is popular and successful. Enrollment has increased every year since 2004 and reached 14.4 million individuals in 2013, which represents 28 percent of the Medicare population.[1]

Seniors choose MA plan over the traditional Fee For Service (FFS) for numerous reasons, but key among them are access to coordinated care, preventative care services, supplemental benefits, and lower out of pocket liabilities.

As a result of the fixed payment per enrollee, Medicare Advantage plans are designed with the financial incentive to keep patients healthy and provide the best care in cost-effective settings; often this means coordinated care. This differs from the silos, duplicative care, and lack of provider communication that characterize FFS Medicare. In fact, traditional Medicare is changing itself with Accountable Care Organizations and other care coordination efforts, to become more like many MA plans.

[1] http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/

Successful MA plans are tremendously innovative in how they work with seniors to manage chronic conditions and post-acute care. Plans are experimenting with both high-tech and low-tech solutions, everything from surgery checklists to nurse-led care teams making house calls to wearable telehealth technology in a patient's home. Because they are working with a smaller population and a limited provider network, MA plans can experiment with different payment models and care initiatives to determine affordable solutions for patient care.

In addition, MA plans often offer supplemental services not covered by FFS. This is particularly important for lower-income seniors who may not have other avenues to access dental or vision services. Since there are a range of plans with a variety of supplemental benefits, a Medicare beneficiary with robust plan choice in his area can compare plans and choose one that best suit his or her needs.

Lastly, MA is valuable for seniors without access to retiree coverage or a Medigap plan because the cost sharing is generally lower than FFS and has a maximum cap on out of pocket spending. Seniors paying MA premiums have more predictable annual costs and can better budget for their health care needs.

Impact of ACA Reductions on MA Funding

A central feature of the budgetary structure of the ACA is to pay for the new and expanded entitlement programs by cutting Medicare benefits. The law takes $200 billion from MA payments over 10 years, which is estimated to result in 4.8 million fewer beneficiaries by 2019 compared to the previous enrollment projections.[2] In addition to payment cuts, the law includes a health insurance tax that will be paid by most companies offering MA plans.[3]

There has been much speculation about the impact of the ACA cuts to MA plans. The common threads running through analyses of the MA landscape in 2014 are (1) fewer plan choices, (2) higher costs to beneficiaries, (3) foregone benefits, and (4) tighter provider networks.

The open enrollment period for 2014 is expected to feature 142 fewer MA plans than last year, representing a 5.3 percent decrease, according to a report by Avalere Health.[4] The Kaiser Family Foundation reports a smaller decrease of 60 fewer plans, acknowledging that 349 plans will be discontinued and only 289 plans will enter the market.[5] Areas of the country will experience varying effects; the Avalere Health report mentions that "plan sponsors are responding by reducing their footprint in rural markets," and notes that counties in the South and Midwest regions will see the largest impact. In Iowa, nearly

[2] http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/macomparisons.pdf
[3] http://americanactionforum.org/sites/default/files/Case%20of%20the%20Premium%20Tax.pdf
[4] http://avalerehealth.net/news/avalere-analysis-reveals-first-drop-in-medicare-advantage-offerings-since-2
[5] http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/

10,000 seniors – most of who live in rural areas – have already received cancellation notices.[6] In New Jersey, that number is 50,000.[7] These seniors will have other plans to choose from, but they may pay more in premiums, lose certain benefits and/or no longer have access to their regular physicians. Most importantly, even if they like their current MA plan, they can't keep it.

The Kaiser Family Foundation's Medicare Advantage Spotlight updated November 25, 2013 predicts premiums and out of pocket costs for MA enrollees that do not switch plans will increase in 2014.[8] In addition, the Kaiser Foundation found that average out of pocket caps increased from $4,333 in 2013 to $4,797 in 2014, with 41 percent including caps that topped $5,000.[9] This is particularly disconcerting given the population of MA enrollees; the program draws a significant number of low income and minority beneficiaries.

An analysis of the Medicare Beneficiary Survey done by America's Health Insurance Plans in 2011 provides a breakdown of Medicare enrollment by income level. Among those with incomes below $10,000 annually, 27 percent are enrolled in MA, 47 percent are enrolled in Medicaid, 9 percent have another form of supplemental coverage (either employer-sponsored retiree coverage or a Medigap plan) and only 16 percent have traditional Medicare exclusively. Among those with incomes between $10,000 and $20,000 annually, 33 percent are in MA plans, 22 percent are enrolled in Medicaid, 23 percent have another form of supplemental coverage, and 20 percent have traditional Medicare exclusively. Among the higher-income beneficiaries, MA plans remain popular, drawing in 20 percent of Medicare beneficiaries with annual incomes above $50,000; but 71 percent of this population has other supplemental coverage through their employer or a Medigap plan.[10]

The data mentioned above demonstrate MA's importance for lower income seniors who do not have access to other forms of supplemental coverage to mitigate high out of pocket spending inherent in traditional Medicare – which has no out of pocket cost cap. Keeping MA plans viable and affordable for a lower income senior population should be a top priority for Congress and the administration.

If plans chose to keep cost sharing constant, they will need to absorb the cuts elsewhere. Whether this takes the form of more limited provider networks, a reduction in supplemental benefits, or scaling back plan offerings in certain areas; these cuts will impact MA enrollees, especially those in poor health or dealing with complicated chronic conditions. One insurance firm with a large MA business announced that they would be

[6] http://thegazette.com/2013/10/03/more-than-9200-in-iowa-facing-nonrenewal-of-medicare-advantage-plans/
[7] http://www.nj.com/news/index.ssf/2013/10/obamacare_forces_insurance_companies_to_scrap_some_plans_create_new_ones.html
[8] http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/
[9] http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/
[10] http://www.medicarechoices.org/pdf/LowIncomeMinorityBenMA2011.pdf

scaling back their provider networks in MA plans by 10-15 percent.[11] Other MA plans with prescription drug benefits may change which drugs are covered.[12]

Conclusion

The majority of recent attention on the ACA has focused on the failing exchange websites, dramatically increased premiums for young adults, and cancelled health insurance plans for those in the individual market. The impact on seniors' MA plans is yet another reminder of the ACA's broken promises. Despite the president's assurances that that the ACA would not cause anyone to lose a health insurance plan they liked, the law's dramatic payment cuts guaranteed that some plans would leave the market and others would restructure their benefits in order to remain affordable and viable. Many MA enrollees around the country will get plan cancellation notices, learn that a benefit they previously had has been stripped from their plan, or find out that a doctor they had a relationship with is no longer in the network.

In closing I would urge Congress and the administration to reconsider the planned cuts to MA. MA is a high-value option and beneficiaries will benefit from robust plan choices as the means to receive high quality, coordinated care and limit their out of pocket spending. The ACA promise of unaltered coverage for those content with their insurance has already been broken as the law makes it impossible for many MA enrollees to continue with the *status quo*. Continued cuts will simply magnify this fact. Further, much of MA's value is based on the plans' ability to innovate and offer needed additional benefits, both of which are compromised in the face of large payment rate cuts.

[11] http://abcnews.go.com/Business/wireStory/keys-scrutinizing-medicare-advantage-cuts-20876062
[12] http://www.oregonlive.com/finance/index.ssf/2013/10/medicare_2013_how_the_affordab.html

Mr. PITTS. The Chair thanks the gentleman and now recognizes Mr. Baker 5 minutes for summary of his opening statement.

STATEMENT OF JOE BAKER

Mr. BAKER. Thank you, Chairman Pitts and Ranking Member Pallone and distinguished members of the subcommittee.

Medicare Rights is a national nonprofit organization that works to ensure access to affordable care for older adults and people with disabilities, and we thank you for this opportunity to testify on the Medicare Advantage program.

Each year we counsel thousands of people with Medicare Advantage about topics ranging from enrolling in a plan to appealing a denied claim. We find that Medicare Advantage plans are a good option for some but not all people with Medicare. Many of our callers are satisfied with their plan and their inquiries are easily resolved. Others find navigating a Medicare Advantage plan challenging. These callers may struggle to resolve billing issues, cope with coverage denials, compare plan details and other issues.

In particular, we observe that people find choosing among Medicare Advantage plans sometimes a dizzying experience. We urge people every year to revisit their plan's coverage as annual changes to plan benefits, cost sharing, provider networks and other coverage rules are commonplace each year. Yet research suggests that inertia is widespread. Put simply, there are too many plans, too many variables to compare and too few meaningful choices among plans.

The Affordable Care Act offers a blueprint for constructing a high-value healthcare system where insurance plans, physicians, hospitals and other providers are paid according to the quality of care that they provide. Medicare is the incubator for many of these reforms. As such, the ACA includes a set of policies designed to make the Medicare Advantage system more efficient and to enhance plan quality. Alongside physicians, hospitals and other healthcare providers, Medicare Advantage plans have been and should be playing an important role in this transformation.

Medicare Advantage provisions included in the ACA are ultimately intended to secure higher-volume care; in other words, better quality at a lower price. Recent changes to MA by the ACA have strengthened the program. In addition to improving Medicare's overall financial outlook, the ACA enhanced Medicare Advantage through added benefits, fairer cost sharing and improved plan quality. For instance, the ACA expands coverage for preventive services, prohibits Medicare Advantage plans from charging higher cost sharing than original Medicare for renal dialysis, chemotherapy and skilled nursing facility stays and requires that plans spend 85 percent of beneficiary premiums and Federal payments on patient care. These and other changes that the ACA has brought to Medicare Advantage should be preserved.

It is important to note that ACA savings secured largely from Medicare Advantage payment adjustments are producing positive returns for the Medicare program benefiting both current and future beneficiaries. Improving cost efficiency in Medicare translates into real progress for older adults and people with Medicare and

people with disability. For example, in 2014, the Part B premium remains at its 2013 level, amounting to $104.90 per month.

While many predicted that ACA changes to Medicare Advantage would lead to widespread disruption of the plan landscape, we have not seen that among our clients that we serve generally. The premiums, benefit levels and availability of plans remain relatively stable. In fact, the Medicare Advantage market is now better and more robust for consumers, and enrollment continues to be on the rise in this year.

While there appears to be an increased incidence of slimming of Medicare Advantage provider networks this year, we must stress that we see this every year. Changing provider networks are an inherent risk of any managed care system. Our advice to Medicare beneficiaries remains the same: people can switch to another Medicare Advantage plan or back to original Medicare or traditional Medicare during the fall open enrollment period, which is occurring right now, in any situation where a current Medicare Advantage plan does not meet their needs.

In closing, we believe that Congress should do more to simplify plan selection and coverage rules for people with Medicare Advantage. We recommend improving beneficiary notice regarding annual plan changes including changes in plan networks and further streamlining and standardizing plans, improving the appeals system, and adequately funding independent counseling resources like the SHIP program. We also urge Congress to expand the range of supplemental coverage options available to people with original Medicare for those cases where a Medicare Advantage plan is not the best fit for beneficiaries' needs and also to allow people to go back and forth between the Medicare Advantage plan and the original Medicare program with more facility.

We really thank you for the opportunity to testify today.

[The prepared statement of Mr. Baker follows:]

MEDICARE RIGHTS

Summary of Testimony by Joe Baker, Medicare Rights Center

The Medicare Rights Center is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

People with Medicare Advantage: Medicare Rights counsels thousands of people with Medicare Advantage (MA) each year. Today, 15 million Medicare beneficiaries (29%) are enrolled in MA. The most common call to our national helpline comes from a beneficiary who is having difficulty affording a health care service or a prescription medicine. Other calls concern:

- **Denied claims and appeals:** Of all calls received on Medicare Rights' helpline in 2012, 33% concerned appeals, and the majority of these related to MA denials of coverage. Research shows that MA enrollees are more likely to report access problems than those with Original Medicare.

- **Enrollment and disenrollment:** Older adults and people with disabilities find choosing among multiple MA plans a dizzying experience. Despite regular plan changes, research suggests that inertia is widespread and most people with Medicare fail to reevaluate their coverage options on an annual basis. There are *too many* MA plans, *too many* plan variables to compare, and not enough meaningful variation among options.

Medicare Advantage Strengthened Since the Affordable Care Act: The ACA included a set of policies designed to make the MA system more efficient and to enhance plan quality. Some claimed that MA enrollees would experience increased cost sharing, tightened provider networks, and fewer plan choices as a result of changes to MA payments, but this has not proven true.

While there appears to be some slimming of MA provider networks this year, these adjustments are an *inherent risk* of any managed care system, have happened in the past, and will happen in the future. Our advice to beneficiaries remains the same: people can change their coverage during the Fall Open Enrollment Period (November 15 – December 7) if an MA plan no longer meets their health and financial needs.

ACA savings secured largely from MA payment adjustments are producing positive returns for the Medicare program overall, benefiting both current and future beneficiaries. The ACA made many other critical improvements to MA, benefiting people with Medicare and their families, including:

- Enhancing coverage and reducing costs for select preventive services
- Prohibiting higher cost sharing for renal dialysis, chemotherapy, and skilled nursing stays
- Mandating a medical loss ratio requiring that 85% of premiums and MA payments are spent on care

Recommendations to Improve Medicare Advantage:

- Improve beneficiary notices regarding annual plan changes
- Further streamline and standardize plans
- Strengthen the MA appeals system
- Adequately fund independent counseling resources, namely State Health Insurance Programs (SHIPs)
- Expand access to supplemental coverage options for people with Original Medicare
- Approach with caution V-BID models to increase cost sharing for some beneficiaries

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Testimony of Joe Baker
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Prepared for the
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Energy & Commerce Committee, Subcommittee on Health

"Medicare Advantage: What Beneficiaries Should Expect Under the President's Health Care Plan"

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Introduction:

Chairman Pitts, Ranking Member Pallone, and distinguished members of the Subcommittee on Health, I am Joe Baker, President of the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

Thank you for the opportunity to testify on the future of Medicare Part C, also known as Medicare Advantage (MA or MA-PD).[1] Our testimony will describe common beneficiary experiences with MA, explain the benefits of recent MA changes for current and future Medicare beneficiaries, offer policy options to further strengthen MA, and explain some concerns we have about increasing beneficiary cost sharing through value-based insurance design.

Medicare Rights counsels thousands of people with MA about topics ranging from enrolling in a plan to appealing a denied claim. Our experience serving MA enrollees informs our support for changes made to MA plans by the Affordable Care Act (ACA) as well as other improvements advanced by the Centers for Medicare & Medicaid Services (CMS). MA enhancements made possible by the ACA include equalizing MA and Original Medicare payments, limiting cost sharing for select services, establishing quality measurement initiatives, and more.

We believe that the ACA begins to advance a value-driven agenda for transforming our health care system. Medicare is the testing ground for many critical payment reforms, and we believe that MA plans, alongside Medicare physicians, hospitals, and other health care providers, are contributing to and should play a role in this broader transformation.

While many predicted that ACA changes to the MA landscape would lead to widespread disruption of the MA market, we have not seen that among the clients we serve or generally, as

[1] MA plans cover Medicare Part A and Part B; MA-PD plans cover Medicare Part A, Part B and Part D

described below. The premium costs, benefit levels, and availability of MA plans remains relatively stable. In fact, the MA landscape is now better and more robust for consumers. In the current open enrollment period, we received a trickle, not a torrent, of calls to our helpline from MA members who recently discovered that their physician or other provider is no longer in their plan network in 2014. While there appears to be an increased incidence of slimming MA provider networks this year, it is important to note that we see some version of this every year. Put simply, changing provider networks are an *inherent risk* of any managed care system. Plans are free to alter networks, and providers are free to leave or join networks throughout the year.

In short, MA adjustments to provider networks are business as usual. Our advice to beneficiaries remains the same, people with Medicare can switch to another MA plan or to Original Medicare during the Fall Open Enrollment Period (November 15 – December 7) if an MA plan no longer meets their health and financial needs. As always, we strongly encourage CMS to thoroughly investigate the network adequacy of MA plans as well as a given plan's reasoning behind any sizable changes to provider networks, particularly in cases where CMS is hearing concerns directly from beneficiaries.

Drawing on our experience serving people with Medicare, we find that MA plans are a good option for some beneficiaries, but not for all. It is critical that Original Medicare is preserved as a strong, viable coverage option, and we urge Congress to improve access to supplemental Medigap coverage options. All in all, we find that the MA market has vastly improved in recent years as a result of policies advanced by the ACA and CMS to stabilize beneficiary cost sharing, streamline plan choices, and enhance the quality of MA plans.

People with Medicare Advantage

Medicare Rights knows firsthand the economic and health challenges facing people with Medicare. Medicare Rights answers 15,000 questions on our national helpline each year, serving older adults, people with disabilities, and those that help them—family caregivers, social workers, attorneys and other service providers. Through our educational initiatives, including peer-to-peer learning networks, we touch the lives of another 140,000 people with Medicare and

their families. In addition, our online learning tool, Medicare Interactive, receives approximately 1.1 million visits annually.

Today 15 million Medicare beneficiaries (29%) are enrolled in an MA plan.[2] The top four questions from MA callers to the Medicare Rights helpline involve the following topics: (1) billing for services or products provided; (2) coverage of health services or prescription drugs; (3) denied claims; and (4) enrollment and disenrollment. Many of our callers are satisfied with their MA coverage, and their inquiries are easily resolved. Others find navigating their MA plan challenging. These callers may struggle to resolve billing disputes, cope with coverage denials, compare plan details during open enrollment, and more.

Mr. Johnson is one such caller, who recently called our helpline for assistance resolving a billing dispute with his MA-PD plan for an expensive medication. Mr. Johnson and his wife live in Tennessee on $1,600 per month from Social Security. Before filling his prescription, Mr. Johnson called his MA plan to double check on the copayment and was informed his epilepsy medicine would cost $544 for a three-month supply. However, when Mr. Johnson paid for the medication he was charged a higher amount, $805.

Alarmed by this, Mr. Johnson called the MA plan and was told that the $544 cost described on a prior call was merely an estimate. Since then, he has spoken with several plan representatives and cannot obtain a clear answer on the exact amount of the medication copayment. A Medicare Rights counselor helped Mr. Johnson file a written grievance and assisted him with Plan Finder, the online search tool made available by CMS, to assess other MA plan options during this year's open enrollment period.

The most common call to our helpline comes from a Medicare beneficiary, like Mr. Johnson, who is having difficulty affording a health care service or a prescription medicine. We receive these calls from both people with Original Medicare and from those with MA. In 2012, half of

[2] Gold, M., Jacobson, G., Damico, A., and T. Neuman, "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums," (Kaiser Family Foundation: November 2013), available at: http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/

all Medicare beneficiaries lived on annual incomes at or below $22,500—just under 200% of the federal poverty level. One in four had incomes of less than $14,000. The Baby Boomers, many of whom will retire within the next two decades, are not expected to fare much better. In 2030, half of all people with Medicare are expected to have annual incomes at or below $28,600.[3]
In 2012, one third of our helpline calls concerned coverage denials and appeals, most commonly from MA enrollees. Additionally, a core helpline service involves counseling beneficiaries about their options during Medicare's annual enrollment period (November 15 – December 7). In 2012, Medicare Rights fielded more than 2,500 Plan Finder related calls during open enrollment.

In general, we find that older adults and people with disabilities find choosing among multiple MA plans a dizzying experience. We urge people with MA to revisit their plan's coverage each year, as annual changes to plan benefits, cost sharing, provider networks, utilization management tools, and other coverage rules are commonplace. Despite regular plan changes, research suggests that inertia is widespread and most people with Medicare fail to reevaluate their coverage options on an annual basis.[4] Mr. Johnson, for instance, had not revisited his MA plan selection for several years because he found Plan Finder "too confusing." Like Mr. Johnson, many beneficiaries are overwhelmed by the number of plans available and the process of comparing multiple complex variables to select among these plans.

A recent *Health Affairs* study attributes some degree of beneficiary inertia with having too many plans to choose from. The authors write, "Our study suggests that the Medicare Advantage program presents an overabundance of choices for elderly beneficiaries, posing a level of complexity far beyond that experienced by the nonelderly." Additionally, the findings show that

[3] J. Cubanski, "Testimony: An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicare-beneficiaries-costs-and-service-use-testimony.pdf; Jacobson, G., Huang, J., Neuman, T. and K. Smith, "Widespread Disparities in the Income and Assets of People with Medicare by Race and Ethnicity: Now and in the Future," (Kaiser Family Foundation: September 2013), available at: http://kff.org/medicare/report/wide-disparities-in-the-income-and-assets-of-people-on-medicare-by-race-and-ethnicity-now-and-in-the-future/

[4] Hoadley, J., Hargrave, E., Summer, L., Cubanski, J., and T. Neuman, "To Switch or Not to Switch: Are Medicare Beneficiaries Switch Drug Plans to Save Money?" (Kaiser Family Foundation: October 2013), available at: http://kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicare-beneficiaries-switching-drug-plans-to-save-money/?special=footnotes - footnote-87213-9

difficulty selecting among MA plans and Original Medicare is more pronounced among older adults with low cognitive function, such those in the early stages of dementia.[5]

While some had predicted that the advent of the ACA would mean that the number of MA plans available to people with Medicare would decrease dramatically, that has not proven true. Medicare beneficiaries continue to have a range of possible plans and plan types, with some positive consolidation in the numbers of plan choices. Some of this reduction in the number of plans is the result of efforts on the part of CMS to eliminate nearly identical plans offered by the same insurer in the same market, which added confusion, but no real choice, to the MA landscape.

In 2014, the average Medicare beneficiary will have a choice among 18 MA plans, compared to an average of 20 in 2013.[6] Nearly all beneficiaries (99%) will have one or more plans to choose from in 2014, and nearly all will have a range of plan types to select from, 89% will have access to a Health Maintenance Organization (HMO) and 83% to a local Preferred Provider Organization (PPO). Consistent with past years, beneficiaries in urban areas will have more plan choices than those in suburban and rural areas.[7]

Looking beyond enrollment challenges, our experience demonstrates and available research confirms that there is no one size fits all choice for people with Medicare. Studies suggest that it is particularly difficult for people with MA to estimate expected costs apart from plan premiums, for example for copayments and coinsurance.[8] One analysis of MA plan cost sharing estimated that average annual spending by a Medicare beneficiary in poor health (using a specified set of health care services) ranged from $1,360 to $7,520 across 88 MA plans.[9] Additional research

[5] McWilliams, J.M., Afendulus, C.C., McGuire, T.G., and B.E. Landon, "Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decisionmaking," *Health Affairs* 30:9 (September 2011)
[6] Gold, M., Jacobson, G., Damico, A., and T. Neuman, "Medicare Advantage 2013 Spotlight: Plan Availability and Premiums," (Kaiser Family Foundation: December 2012), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8388.pdf
[7] Gold, M., Jacobson, G., Damico, A., and T. Neuman, "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums," (Kaiser Family Foundation: November 2013), available at: http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/
[8] O'Brian, E. and J. Hoadley, "Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice," (Commonwealth Fund: April 2008), available at: http://www.commonwealthfund.org/~/media/Files/Publications/Issue Brief/2008/Apr/Medicare Advantage_Options for Standardizing Benefits and Information to Improve Consumer Choice/OBrien_Medicare_Advantage_options_1117_ib pdf.pdf
[9] Ibid

suggests that disenrollment from MA plans to Original Medicare occurs disproportionately among higher-cost, sicker beneficiaries.[10]

According to another study, MA enrollees were less likely than people with Original Medicare to have health care expenditures exceed 10% of their income. At the same time, however, MA beneficiaries were more likely to report access problems and to give their insurance a fair or poor rating overall. Over one third (32%) of people with MA in the study reported access problems, compared to 23% among people with Original Medicare.[11] Indeed, of all calls received to the Medicare Rights helpline in 2012, 33% concerned questions about appeals, and the majority of these related to MA and MA Part D denials of coverage.

Based on our experience serving people with MA, we believe that Congress should consider policy options to improve the MA landscape. In particular, federal policymakers should prioritize solutions that simplify the annual process of comparing and contrasting plan options, and ensure that unbiased counseling resources, most notably the State Health Insurance Assistance Programs (SHIPs), are adequately resourced to meet beneficiary needs. Additionally, Congress should expand and strengthen supplemental coverage options for beneficiaries whose health and financial needs are not best served by an MA plan.

Medicare Advantage: Strengthened Since the Affordable Care Act

Delivery system and payment reforms are now being implemented in the private sector, in Medicare, and in other public programs, through a variety of initiatives, many of which were made possible by the ACA. The ACA offers a blue print for constructing a high value health care system, where insurance plans, physicians, hospitals, and other providers are paid according to the quality of care delivered.

[10] Riley, D., "Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-for-Service," (CMS Center for Strategic Planning: 2012), available at: http://www.cms.gov/mmrr/Downloads/MMRR2012_002_04_A08.pdf

[11] Davis, K., Stremikis, K., Doty, M.M., Zezza, M.A., "Medicare Beneficiaries Less Likely to Experience Cost- and Access-Related Problems Than Adults with Private Coverage," *Health Affairs* 31:8 (August 2012); Davis, K. "The Future of Medicare: Converting to Premium Support or Continuing as a Guaranteed Benefit Program," (Invited Testimony to the House of Representatives Democratic Steering and Outreach Committee: October 2012), available at: http://www.commonwealthfund.org/~/media/Files/Publications/Testimony/2012/Oct/Davis_HouseDems_Medicare_testimony_10022012_FINAL.pdf

Medicare is the incubator for many of these reforms.[12] As such, the ACA included a set of policies designed to make the MA system more efficient and to enhance the quality of MA plans. Transforming our health system from one that rewards high-volume care to one that rewards high-value care is a goal shared by members of Congress on both sides of the aisle. Alongside physicians, hospitals, and other health care providers, MA plans have been, and should be, playing an important role in this transformation. The MA provisions included in the ACA are ultimately intended to secure high value care—in other words, better quality at a lower price.

Among the most notable ACA changes to MA were adjustments to plan payments. In 2010 and 2011, maximum MA plan payments were frozen. Beginning in 2012, gradual reductions in plan payments were phased in according to county-specific per beneficiary spending rates in Original Medicare.[13] These adjustments are intended to scale back payments to MA plans to better approximate payments and costs in Original Medicare.

In 2009, before passage of the ACA, Medicare paid MA plans $14 billion more for care than if the same care had been provided under Original Medicare, about $1,000 more per beneficiary. According to MedPAC, on average MA plans were paid 114% of costs under Original Medicare. These payments varied by plan type, for instance the average HMO was paid 113% whereas the average local PPO was paid 118%.[14] From 2004 to 2009 these payments cost the Medicare program nearly $44 billion, and despite being paid more, there was little evidence to suggest that MA plans provided consistently higher quality care. [15]

As noted above, some claimed that people with MA would experience increased premiums and cost sharing, tightened provider networks, and fewer plan choices as a result of these payment adjustments. The Congressional Budget Office (CBO), American Health Insurance Plans (AHIP)

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[12] Blum, J., "Delivery System Reform: Progress Report from CMS" (Invited Testimony to the Senate Finance Committee: February 2013), available at:
http://www.finance.senate.gov/imo/media/doc/CMS%20Delivery%20System%20Reform%20Testimony%202.28.13%20(J.%20Blum).pdf
[13] Gold, M. "Making Sense of the Change in How Medicare Advantage Plans are Paid," (Commonwealth Fund: May 2013), available at:
http://www.commonwealthfund.org/Publications/Issue-Briefs/2013/May/Making-Sense-of-Changes-in-Medicare-Advantage-Plans.aspx
[14] MedPAC, Report to the Congress: Medicare Payment Policy," (March 2009), available at:
http://www.medpac.gov/documents/mar09_entirereport.pdf
[15] Angles, J. "Health Reform Changes to Medicare Advantage Strengthen Medicare and Protect Beneficiaries," (Center on Budget and Policy Priorities: July 2010), available at: http://www.cbpp.org/cms/?fa=view&id=3243

and others even predicted that enrollment in MA plans would decline after implementation of the ACA. Yet, the opposite has proven true.

MA enrollment is on the rise, increasing 30% from 2010 to 2013.[16] According to the most recent CBO projections, MA enrollment will continue to increase, with an expected 21 million enrollees in 2023.[17] In short, ACA payment adjustments to MA are not expected to weaken enrollment, and predictions that the MA market will falter have not held up. As implementation of the ACA is carried out, we will continue to advocate for vigilant monitoring of the MA plan landscape to ensure plans are optimally serving people with Medicare under the new payment system.

Critically, ACA savings secured largely from MA payment adjustments are producing positive returns for the Medicare program overall, benefiting both current and future beneficiaries. First and foremost, improved cost efficiency in Medicare translates into tangible savings for older adults and people with disabilities, both for those with Original Medicare and for MA enrollees. In 2014, the Part B premium (paid by both people with Original Medicare and MA enrollees) will remain at 2013 levels, amounting to $104.90 per month.[18] This news is particularly notable given that MA overpayments historically drove up premiums for Medicare beneficiaries. For instance, in 2009, a couple with Original Medicare paid $86 more in premiums as a result of MA overpayments.[19]

Importantly, the ACA put the Medicare program on sound financial footing, reducing projected Medicare spending by $716 billion from 2013 to 2022.[20] According to the 2013 Medicare Trustees Report, the Medicare Hospital Insurance (HI) trust fund is solvent through 2026,

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[16] Jacobson, G., "Projecting Medicare Advantage Enrollment: Expect the Unexpected?" (Kaiser Family Foundation: July 2013), available at: http://kff.org/medicare/perspective/projecting-medicare-advantage-enrollment-expect-the-unexpected/

[17] CBO, "CBO's May 2013 Medicare Baseline," (May 2013), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205_Medicare_0.pdf

[18] CMS, "Press Release: CMS announces major savings for Medicare beneficiaries," (October 2013), available at: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-10-28.html

[19] Angles, J. "Health Reform Changes to Medicare Advantage Strengthen Medicare and Protect Beneficiaries," (Center on Budget and Policy Priorities: July 2010), available at: http://www.cbpp.org/cms/?fa=view&id=3243

[20] CBO, Letter to the Honorable John Boehner re: cost/revenue from ACA repeal (July 2012), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf

extended by ten years since passage of the ACA.[21] This represents one of the longer periods of projected solvency throughout the program's history.[22]

In addition to reining in payments to MA plans, the ACA made many other critical improvements to MA for people with Medicare. For instance, an added benefit for people with Original Medicare and MA is increased coverage and lower cost sharing for select preventive services, like mammograms, colonoscopies, prostate cancer screenings, depression screenings, obesity screenings and counseling, and more. In 2012, an estimated 34.1 million people with Medicare utilized a preventive service with limited cost sharing.[23] MA-PD enrollees are also benefiting from ACA provisions to close the prescription drug coverage gap, known as the doughnut hole.[24]

The ACA also limited the ability of MA plans to charge higher cost sharing than Original Medicare for certain services, particularly those used disproportionately by sicker beneficiaries.[25] Specifically, as of 2011, MA plans are prohibited from charging higher cost sharing for renal dialysis, chemotherapy, and skilled nursing facility stays. In addition, starting in 2014 plans must adhere to a Medical Loss Ratio (MLR). The MLR requires that plans spend 85% of beneficiary premiums and federal payments on patient care, limiting plan spending on marketing, CEO salaries, profits, and other administrative costs.[26]

Finally, the ACA established critical initiatives designed to improve MA plan quality. Specifically, the ACA ties payment bonuses to star ratings for MA plans. Ratings range from 1 to 5 stars, starting with 1 star for poor performance, 3 stars for average performance, and 5 stars for excellent performance. Ratings are determined through a wide array of performance measures.

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[21] The Board of Trustees, "2013 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplemental Medical Insurance Trust Fund," (May 2013), available at: http://downloads.cms.gov/files/TR2013.pdf

[22] P.A. Davis, "Medicare: History of Insolvency Projections" (Congressional Research Service: June 2012), available at: http://www.fas.org/sgp/crs/misc/RS20946.pdf

[23] CMS, "The Affordable Care Act: A Stronger Medicare Program," (February 2013), available at: http://www.cms.gov/apps/files/Medicarereport2012.pdf

[24] Kaiser Family Foundation, "Explaining Health Reform: Key Changes to the Medicare Advantage Program," (May 2010), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8071.pdf

[25] Angles, J. "Health Reform Changes to Medicare Advantage Strengthen Medicare and Protect Beneficiaries," (Center on Budget and Policy Priorities: July 2010), available at: http://www.cbpp.org/cms/?fa=view&id=3243;

[26] Ibid

Starting in 2012, MA plans with 4 or 5 stars began receiving bonus payments. At the same time, CMS launched a demonstration program providing more modest bonuses to 3 and 3.5 star MA plans and increasing bonuses across the board in an effort to more rapidly enhance plan performance through 2015.[27] In addition to rewarding and incentivizing high quality plans, the star rating system allows CMS to track poor performing plans and to encourage beneficiaries remaining in an MA plan ranked 3 stars or less for three consecutive years to switch to a better performing plan. CMS also has the option to terminate these plans altogether.[28]

Data available to date suggests that these pay-for-performance initiatives are improving MA plan quality. Over one quarter of MA plans improved their star ratings since 2013, with 11 plans now boasting 5 stars as opposed to a mere three plans in 2011. These increased ratings reflect improvement across several measures including: adult BMI assessment, colorectal cancer screening, controlling high blood pressure, use of high-risk medications among older adults, persistent beta blockers after health attack, and smoking cessation.[29] According to the Department of Health and Human Services (DHHS), more than half of people with MA are now enrolled in a 4 or 5 star plan, up from 37% in 2012.[30]

While the ACA served as a platform for several notable improvements to MA, CMS recently implemented key regulatory changes that further strengthened MA plans. In 2011, CMS required that MA plans include an out-of-pocket maximum on beneficiary cost sharing no higher than $6,700 annually and strongly encouraged plans to adopt a limit of $3,400 or less. In 2014, the average out-of-pocket maximum among MA plans will amount to $4,797.[31]

Additionally, as previously mentioned, CMS undertook efforts to consolidate duplicative and low-enrollment plans.[32] Reducing the number of nearly identical offerings addresses some of the

[27] Kaiser Family Foundation, "Medicare Advantage Plan Star Ratings and Bonus Payments in 2012," (November 2011), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8257.pdf
[28] Cotton, P., "Medicare Advantage Pay for Performance Results," (NCQA presentation to 9th Annual Medicare World Congress: July 2013)
[29] Ibid
[30] DHHS, "Pres Release: More, Higher Quality Options for Seniors in Medicare Advantage," (September 2012), available at: http://www.hhs.gov/news/press/2013pres/09/20130919b.html
[31] Gold, M., Jacobson, G., Damico, A., and T. Neuman, "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums," (Kaiser Family Foundation: November 2013), available at: http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/
[32] Ibid

problems, highlighted above, that beneficiaries face when choosing a plan. People are better able to make good decisions when there are a reasonable number of options, with meaningful differences among them.

In sum, recent changes to MA advanced by the ACA and CMS have strengthened MA plans for current and future enrollees. In addition to improving the overall financial outlook for the Medicare program, the ACA enhanced MA on several fronts, including through added benefits, fairer cost sharing, and improved plan quality. We expect the effects of these changes will only become more pronounced for people with Medicare over time.

Recommendations to Improve Medicare Advantage

ACA provisions to improve MA and recent actions by CMS provide a starting point for considering options to further strengthen MA plans. First and foremost, we believe that it is critically important to preserve the MA payment and cost sharing improvements advanced by the ACA. Additionally, we urge Congress to consider the following recommendations:

Provide improved notice to people with Medicare about plan changes: Congress and CMS should look for opportunities to provide more detailed and advanced notice to MA enrollees about changing plan networks, cost sharing, and other coverage rules. In light of recent MA network changes, federal policymakers should investigate the efficacy of current notices and the timeliness of those notices, such as by revisiting standardized language included in the Annual Notice of Change (ANOC). CMS should be vigilant in its oversight of plan behavior, ensuring that notice is properly delivered, transition planning is provided as appropriate, and unbiased counseling sources are prominently advertised.

Encourage meaningful variation among plans: As reflected in numerous studies as well as our experience serving helpline callers, many people struggle to select among several MA plans and multiple, complex plan variables. To encourage efficient plan selection, distinctions among plans must be made more meaningful, furthering recent efforts by CMS to eliminate plans too alike to other plans offered by the same insurer. At the same time, members of Congress should consider

standardizing MA benefit packages, similar to the rubric required for supplemental Medigap plans (i.e., Plan A, Plan B, Plan C), to encourage "apples-to-apples" comparisons.[33]

Enhance star ratings: As discussed above, the MA and Part D star rating system shows considerable promise as a vehicle to improve both plan quality and access to information about the merits of a given health plan. In the short term, efforts to improve the star rating system should ensure that beneficiaries are informed and engaged, as many people with Medicare are still unfamiliar with the system. Clear, regular explanations of the rationale, meaning and importance of the star rating system are needed. In addition, stars should reflect timely quality measures so beneficiaries can make choices based on the most recent data available.[34]

In the long term, the star rating system should be enhanced to provide consumer-directed information relevant to individual choices. As the program evolves, people with Medicare should be able to "self-weight" various factors to create individualized quality ratings, sorting plans by the metrics most relevant to their individual needs.

Support consumer counseling services: As a consumer service organization, Medicare Rights knows firsthand the importance of personalized counseling as a resource to assist people with Medicare and their families about MA plan choices. As part of New York's Health Insurance Information Counseling and Assistance Program, which is part of the SHIP network, we know the value of this federal resource administered by the states for older adults and people with disabilities. Adequate funding for SHIPs nationwide is absolutely vital to ensuring that people with Medicare are supported in making plan decisions. Supported by federal, state and local funding, SHIPs are the go-to resource for people with Medicare and their families who have questions about Medicare and related programs.

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[33] O'Brian, E. and J. Hoadley, "Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice," (Commonwealth Fund: April 2008), available at: http://www.commonwealthfund.org/~/media/Files/Publications/Issue Brief/2008/Apr/Medicare Advantage Options for Standardizing Benefits and Information to Improve Consumer Choice/OBrien_Medicare_Advantage_options_1117_ib pdf.pdf; Precht, P., Lipschutz, D. and Burns, B., "Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans," (California Health Advocates and Medicare Rights Center: September 2007), available at: http://cahealthadvocates.org/_pdf/advocacy/2007/InformedChoice.pdf

[34] Goggin-Callahan, D. "New York's Medicare Marketplace: Examining New York's Medicare Advantage Plan Landscape in Light of Payment Reform," (Medicare Rights Center: June 2012), available at: http://www.medicarerights.org/pdf/New-York's-Medicare-Marketplace.pdf

In addition to the above, federal policy makers should ensure that MA marketing materials, notices, and websites are additionally simplified and standardized with plain-language information. As a requirement, these plan resources should include a prominent referral to unbiased counseling resources for beneficiaries, including SHIPs and 1-800-MEDICARE. At the same time, Plan Finder should be improved, specifically through enhanced information and comparison tools related to plan provider networks.

In particular, plans should be prohibited from asserting or implying that standard benefits, like an out-of-pocket cap or free preventive services, are unique to the plan. Similarly, plans should not be permitted to suggest that income-based benefits, like the Medicare Savings Programs (MSPs) or the Low-Income Subsidy of Medicare Part D (also known as Extra Help), are dependent on enrolling in a particular MA plan. Rather, these benefits are available to all Medicare beneficiaries, whether enrolled in Original Medicare or an MA plan.

Deliver better information on appeals: We believe that beneficiaries should receive clearer, timelier information about appeal rights. In addition, federal policy makers should demand that data concerning plan denial rates and decision reversals—meaning that a plan denial is subsequently overturned by an independent review—be made public. Increased transparency concerning plan-level denials and appeals would arm CMS, members of Congress, consumer stakeholders, and others with information to investigate possible plan practices, such as blanket denials, rubber-stamped redeterminations, or overly restrictive medical review practices.

Allow continuous open enrollment for Medigap plans: The ACA modified Medicare open enrollment periods, for instance, through the creation of a 45-day Medicare Advantage Disenrollment Period (MADP) (January 1 – February 15) to allow people with MA to switch back to Original Medicare and a Part D plan should they decide that an MA plan is not meeting their needs. Special Enrollment Periods (SEPs) are also allowed for those enrolled in an MA plan that is leaving their area, those moving away from their plan's area, those enrolled in low-income assistance programs and those who desire to enroll in a 5 star MA plan.[35]

[35] Medicare Interactive, "Changing Your Medicare Advantage (private health) plan," (2013), available at: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=1064

Despite this flexibility, some beneficiaries find that their options are limited when MA no longer meets their needs because federal law does not usually give these individuals the right to purchase a Medigap supplemental plan to wrap around Original Medicare. Under federal law, people with Medicare have Medigap guaranteed issue and open enrollment rights—the ability to buy a Medigap without pre-existing condition exclusions, medical underwriting, or plan refusals—only when first becoming eligible for Medicare at age 65 or in other very limited circumstances, although some states have more generous laws.[36]

Allowing Medicare beneficiaries to continuously enroll in Medigap would facilitate broader access to needed coverage in the event an MA plan ceases to be an appropriate choice for a given person's health and financial needs. Anecdotally, we see that in states like New York with continuous open enrollment for Medigap some individuals are more likely to try an MA plan, knowing they can return to Original Medicare and a Medigap if they find that the MA is not the best choice for them.

Require sale of Medigap plans to people with disabilities: Federal law does not require insurers to issue Medigap plans to Medicare-eligible individuals under the age of 65, limiting affordable coverage options for people who qualify for Medicare due to a disability in many states.[37] Congress should establish nationwide guaranteed issue and open enrollment periods for Medigap plans for this population to facilitate broader access to coverage options when an MA plan is not well-suited to a beneficiary's health and financial needs.

Introduce Medicare Part E: Members of Congress should consider adding or pilot-testing a voluntary, publicly-administered supplement (referred to by some as Medicare Part E) to Original Medicare that includes a combined Medicare Part A and B deductible, a catastrophic cap, reduced coinsurances for Medicare Part B, and a drug benefit with limited copayments or coinsurance. Paid for through beneficiary premiums, this public supplement would achieve

[36] Medicare Interactive, "Protected Times to Buy a Medigap," (2013), available at: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=816; Huang, J.T., Jacobson, G., Neuman, T., "Medigap: Spotlight on Enrollment, Premiums and Recent Trends," (Kaiser Family Foundation: April 2013), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8412-2.pdf

[37] Ibid

savings by building on the efficiencies of Original Medicare, reducing administrative costs, and diminishing the need for coordination among multiple sources of coverage. A Medicare Part E plan would exist alongside the private MA and Medigap supplemental market, allowing beneficiaries a baseline plan from which to compare insurance choices.[38]

Cautionary Notes on Adopting V-BID in Medicare Advantage

Some academics, health plans, and others suggest that MA plans should be allowed to alter plan cost sharing on the basis of value or clinical nuance, known as value-based insurance design (V-BID). Under V-BID principles, health plans alter cost sharing for specific services, prescription medicines, or health care providers to encourage beneficiaries to seek out the highest value or most clinically effective care. Now being tested in the private insurance market, V-BID incorporates lower cost sharing for high-value care and higher cost sharing for low-value care.[39]

Medicare Rights strongly supports eliminating or lowering cost sharing to facilitate access to needed, high-value heath care services, such as the policies advanced through the ACA that eliminated Medicare cost sharing for select preventive care. Medicare Rights remains concerned, however, by proposals to increase cost sharing as a deterrent to certain types of care, or as a vehicle for securing savings. Before adopting V-BID in MA plans, we urge Congress to consider the following points:

- Decades of empirical research that demonstrates increased cost sharing disproportionately limits access to care for the poorest, the sickest and diverse populations. [40] V-BID models

[38] Davis, K., Moon, M., Cooper, B., C. Schoen, "Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries" *Health Affairs* Web Exclusive (October 2005); Davis, K., Schoen, C., S. Guterman, "Medicare Essential: An Option to Promote Better Care and Curb Spending Growth" *Health Affairs* v 32 no. 5 (May 2013)

[39] University of Michigan Center for Value-Based Insurance Design, "Implementing Value-Based Insurance Design in Medicare Advantage," (June 2013), available at: http://www.sph.umich.edu/vbidcenter/publications/pdfs/V-BID%20Brief%20Medicare%20Advantage%20June%202013.pdf; Partnership for Sustainable Health Care, "Strengthening Affordability and Quality in America's Health Care System," (April 2013), available at: http://rwjf.org/content/dam/farm/reports/reports/2013/rwjf405432

[40] National Association of Insurance Commissioners, "Medigap PPACA (B) Subgroup" (as of June 2011) available at: http://www.naic.org/committees_b_sitf_medigap_ppaca_sg.htm; See literature under: "Cost-sharing Research and Literature"; Swartz, K. "Cost-Sharing: Effects on Spending and Outcomes" (Robert Wood Johnson Foundation: December 2010), available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1

that incorporate increased cost sharing should be evaluated with the utmost caution, so as not to limit access to needed care for the most vulnerable.

- According to a 2006 RAND study, added cost sharing has little utility in controlling service use once a patient enters the health care system.[41] This finding confirms what we know to be true through our experience serving people with Medicare: health care providers—not beneficiaries—order services and ultimately drive utilization trends.

  In other words, Medicare beneficiaries are not positioned to evaluate high-value versus low-value services. Cost sharing incentives demand a high level of sophistication and knowledge on the part of beneficiaries to evaluate care options that are ultimately recommended by their doctors. V-BID models that increase cost sharing should not be pursued in the absence of complementary efforts to better inform and educate consumers.

- V-BID models may erode "anti-discrimination" provisions included in the Social Security Act. Current rules exist to protect people from discriminatory cost sharing that might limit access to care or make a particular plan less attractive to beneficiaries in need of higher-cost services, effectively skewing a plan risk pool away from people with particular conditions.

- V-BID models now in the private market, related to the selection of prescription medicines, specialists, and hospital systems, are primarily being tested in the private, employer market where the consumers are generally younger, healthier, and have higher incomes than the Medicare population. While promising, V-BID gains seen in the private market may not be transferable to MA plans and may not account for the full scope of risks posed to older adults and people with disabilities.

In sum, based on the points raised above as well as our experience serving vulnerable people with Medicare, we urge members of Congress to proceed with caution before endorsing V-BID models in the MA market.

[41] RAND, "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate" (January 2006), available at: http://www.rand.org/pubs/research_briefs/RB9174.html

Conclusion

In conclusion, the Medicare Rights Center's experience demonstrates that there is no one-size-fits-all insurance option for people with Medicare. For some older adults and people with disabilities, MA plans are a good option. For others, Original Medicare is a better choice. Thanks to recent advancements made possible by the ACA and additional efforts by CMS, the MA market has improved significantly in recent years. ACA improvements to MA plans are producing tangible results for current and future Medicare beneficiaries through stabilized, fairer cost sharing and improved coverage. These changes to MA plans must be preserved.

MA plans play an important role in the value-driven agenda advanced by the ACA. While some may be inclined to sensationalize annual plan changes, like altered cost sharing and trimmed provider networks, and link them to the ACA, it is important to recall that these practices are the norm within the MA landscape. As always, people with MA retain the option of switching their coverage during the Medicare open enrollment period if their plan no longer meets their health and financial needs.

Our experience further shows and empirical research demonstrates that Congress and CMS should do more to simplify plan selection and coverage rules for people with MA. To achieve this goal, we recommend improving beneficiary notice regarding annual plan changes, further streamlining and standardizing plans, improving the MA appeals system, and adequately funding independent counseling resources, such as SHIPs. Importantly, we also urge federal policymakers to expand the range of coverage options available to people with Original Medicare for those cases where an MA plan is not the best fit for a beneficiary's needs.

Thank you for the opportunity to testify.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Dr. Margolis 5 minutes for summary of his opening statement.

STATEMENT OF ROBERT MARGOLIS

Mr. MARGOLIS. Thank you, Chairman Pitts and Ranking Member Pallone and esteemed committee members for the invitation to address you today. I come to address the merits of Medicare Advantage, having had many years of experience in the program, and can tell you without any hesitation, it is the most effective Federal program moving seniors to higher-quality care through coordination and measurement of quality and outcomes.

I come wearing multiple hats as my 40 years in health care and healthcare policy has taken me in many directions: the California Association of Physician Groups, which I chaired and which represents over 90 percent of all coordinated care patients in California, my board representation and chairmanship at NCQA, which has proven through extensive measurement and transparency that the quality and measurement that occurs in Medicare Advantage is superior to the fee-for-service original alternative; as you mentioned, my role as CEO of HCP, HealthCare Partners, but mostly as a doctor at a practice for over 20 years in an urban inner-city hospital in Los Angeles serving primarily seniors and other disadvantaged patients where I saw that without equivocation, the fee-for-service mentality of the original Medicare, or as we like to refer to it, fee for volume, is not coordinating care for seniors.

Seniors who have multiple chronic diseases, who are vulnerable and especially those that are poor and with less than fewer resources, need an ideal system, a system that helps with great information and a physician advisor to help them navigate through a very difficult and complex healthcare system and manage them longitudinally across time. As a physician, I can tell you that every physician I know manages his or her patients with great desire to do the best outcome but does not have the infrastructure, the coordination and the resources to follow that patient longitudinally through their healthcare needs, and that is the one major advantage of coordinated care, population health, managed care, however you choose to name it. Population health, for those that perhaps are unfamiliar with that term, really is having patients select a doctor through a network, through a health plan, and then having that physician organization take responsibility through a per-member per-month or capitation for the total are of that patient. It totally changes the incentives, and incentives drive behaviors. The behaviors within a coordinated care program are one of health promotion, defer and delay chronic disease through much more intervention, disease management, pharmacy management, making sure that patients get to their specialist, get to their visits, have home care programs.

So let me explain a little bit about how that works within our organization, which is relatively large. We care for now over 250,000 Medicare Advantage patients through our 11,000 affiliated and employed physicians in five different States, and the way that works is through great information technology, which is a big investment but an important investment that allows us now to segment the patient population into areas of need and design pro-

grams specifically to those areas of need. So for instance, there are home care programs for those most vulnerable that have trouble getting into the doctor's office and avoids 911 calls and trips to the emergency room. There are comprehensive care clinics for those folks that have very complex diseases where there is individual care plans monitored by a team, and I have to say without equivocation, health care best delivered is a team sport. It is great to have a physician in the center of that team, but having care managers, having disease management, having social workers, having dieticians, having home care capabilities is a key component of making it an effective system, so I ask you without any equivocation, please continue to support MA, strengthen it, help it grow, support special needs program, support moving the duals into Medicare Advantage in a coordinated way with the States. It is a very vulnerable population that could use Congress's support with CMS to make that effective.

And with that, I will yield the last 6 seconds back to you.

[The prepared statement of Mr. Margolis follows:]

CAPG

The Voice of Accountable Physician Groups

Summary of Statement by Dr. Robert Margolis, CAPG

The Delegated Payment Model and Medicare Advantage (MA). Under MA, physician organizations, such as HealthCare Partners (HCP), are paid under a population-based payment model (commonly referred to as capitation). In this model, the Centers for Medicare & Medicaid Services (CMS) makes a payment of premium to health plans. Health plans pay physician groups a defined amount for each enrolled patient for services over a span of time, which is typically a per member, per month payment. Physician groups then have flexibility to structure downstream payments to physicians to incentivize high quality care and low cost care. To ensure that the budget is met in a way that improves patient care, physician groups hold their physicians to the quality reporting and performance standards of the MA 5-Stars program and robust internal quality incentive programs.

Population-Based Payments to Physician Organizations Lead to Better Care for Patients. The population-based payment approach reduces high-utilization incentives of the fee-for-service (FFS) system and creates incentives to improve quality. The MA model incentivizes (1) a team-based approach under which all heath care providers practice at the top of his or her license; (2) physician organizations to provide the right care at the right time in the most appropriate setting; and (3) physicians to address the patient's total care needs, including mental health, behavioral health, and home environment. Savings achieved by keeping patients healthy are reinvested in patient care.

Patient Interest in MA is Growing Because Of Its Positive Results. MA enrollment has grown steadily over the past several years. In many of the areas where HCP operates, over 40 percent of Medicare beneficiaries have selected MA. The benefits that flow to patients are an important factor in the growth in enrollment over the years. Peer reviewed research has consistently shown that MA outperforms FFS Medicare, including in measurements of preventive care and preventable readmissions.

MA is under Stress – Death by a Thousand Cuts. The MA program is under severe stress due to a number of cumulative cuts to the program, including: reductions to MA plan benchmarks; coding intensity adjustment; changes to CMS's risk adjustment methodology; sequestration; and the tax on health insurers. Benchmark reductions alone were intended to bring MA to parity with original Medicare. Additional layered reductions cut deeply into the MA program and flow to patients in the form or fewer physician choices, fewer benefits and increased patient costs. The cuts have the net effect of pushing seniors away from MA and into the fragmented FFS delivery model.

The MA Program Should Be Strengthened, Not Cut. As Congress considers major policy objectives, like sustainable funding of government programs, the debt ceiling, and reforming the sustainable growth rate formula, efforts should be made to strengthen, not weaken the MA program. I ask that Congress refrain from making further blunt cuts to the MA program, which is the best currently-operating alternative to the flawed fee-for-service program. Instead, I respectfully suggest that you can achieve a financially stable Medicare program through strengthening the MA program – the existing Medicare option that encourages greater care coordination, and consistently outperforms FFS, and improves outcomes for seniors.

The Voice of Accountable Physician Groups

Statement of Dr. Robert Margolis
CAPG – the Voice of Accountable Physician Groups
Before the House of Representatives Energy & Commerce Subcommittee on Health Hearing:
"Medicare Advantage: What Beneficiaries Should Expect Under the President's Health Care Plan"
December 4, 2013

Thank you Chairman Pitts, Ranking Member Pallone, and Members of the Health Subcommittee for inviting me to testify today.

I am pleased to testify today on behalf of CAPG. CAPG is the largest association in the country representing physician organizations practicing capitated, coordinated care. CAPG members include over 160 multi-specialty medical groups and independent practice associations (IPAs) across 20 states. CAPG members provide comprehensive health care through coordinated and accountable physician group practices. We strongly believe that patient-centered, coordinated, and accountable care offers the highest quality, the most efficient delivery mechanism, and the greatest value for patients. CAPG members have successfully operated under this budget-responsible model for over two decades.

I am a member of the CAPG Board of Directors and a former Chairman of the organization.

I also address you today as CEO of HealthCare Partners, Co-Chairman of Davita HealthCare Partners, and as a physician. By way of background, HealthCare Partners is a physician organization that provides coordinated and integrated care. HealthCare Partners (HCP) operates in five states, Arizona, California, Florida, New Mexico, and Nevada. We treat approximately 270,000 senior Medicare Advantage patients, 400,000 commercial HMO patients, and 100,000 Medicaid HMO patients. We

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employ over 1,000 physicians and contract with nearly 3,000 primary care doctors and over 7,000 specialists.

As an organization with extensive experience in coordinated care, HCP knows that the way Medicare pays for physician services can either incentivize or disincentivize care coordination. For example, in fee-for-service (FFS) Medicare, physicians are paid for each service provided, and, perhaps understandably, without a real eye toward coordination among other practitioners, prevention, or the health of the larger population. The FFS model incentivizes utilization and drives a high volume of services. The more services a physician provides, the more a physician is paid. In contrast, the Medicare Advantage (MA) program has a long history of a payment structure that incentivizes value. MA creates opportunities and the motivation for physician organizations to focus on care coordination, to build infrastructure to benefit patients, and to improve outcomes and quality.

I recognize that there are efforts underway to move the Traditional Medicare physician payment system to a coordinated care model (e.g., Accountable Care Organizations). I believe that these efforts, when properly structured, can be successful in creating coordinated care for the fee-for-service population. However, to date, Medicare Advantage, with its population-based payments made to physician organizations, is the best example within Medicare of a payment structure that provides appropriate incentives to keep patients healthy, coordinate care across specialists and primary care physicians, and hold physicians and care teams accountable for the quality of services provided.
In my remarks today, I will describe how physicians are paid under the MA program, explain how the payment structure allows physician organizations to invest in and improve patient care, and why the MA program is under stress and should be strengthened by Congress.

I. Background on Delegated Payment Model and Medicare Advantage

Under the MA program, Medical groups and IPAs, such as HCP, are paid under a population-based payment model, also referred to as capitation. In this model, the Centers for Medicare & Medicaid

Services (CMS) makes a payment of premium to health plans. Health plans pay physician groups a defined amount for each enrolled patient for services over a span of time, which is usually a percentage of the premium and often referred to as a per member, per month payment. This fixed payment occurs regardless of the amount of care provided to the patient. In the simplest terms, the physician organization is effectively given a budget to care for a defined group of patients. There is no additional payment for cost over-runs. Physician organizations must manage the population's care needs within the budget. Physician groups hold their employed and contracted physicians to robust quality reporting and performance standards to ensure that the budget is met in a way that improves patient care.

In the "delegated model," which is often used by insurers in MA, medical groups and IPAs are often delegated the administrative duties that in the fee-for-service world are typically performed by insurers. Under the delegated model the medical groups and IPAs perform a wide range of responsibilities associated with care delivery, such as utilization management, claims payment, and quality assurance.

It is important to point out that these population-based payments are made directly to physician organizations. The physician organizations then make downstream payments to primary care and specialty physicians, and sometimes hospitals depending upon the contract with the MA plan. Downstream payments are tailored to provide incentives to achieve the highest quality possible. Downstream payments to the individual physician may take the form of subcapitation, salary, or even FFS payments. (FFS payments are sometimes used when the group wants to incentivize higher utilization for a certain type of service, like preventive services or fitness or wellness program.) The downstream payments also often include payment of bonus incentives for physician performance and outcomes, like quality incentive payments for performance on certain measures. The internal quality measures, evaluations and incentives that physician organizations use tend to be very robust and drive appropriate, high quality care for patients. The internal quality bonus programs are often more

rigorous than the MA Stars program; the two are often carefully and strategically interlinked by the groups.

II. Population-Based Payments to Physician Organizations Lead to Better Care for Patients

The population-based payment made by the MA plan to the physician group creates numerous benefits that are not seen in the fee-for-service environment. The population-based payment methodology allows us to incentivize a team-based approach. This approach deploys other health care professionals, such as care managers, nurses, social workers, care navigators, pharmacists, and other "mid-level" professionals, as part of a team led by a primary care physician. Each team member practices at the top of his or her license. This team-based approach leads to better outcomes for patients and – very importantly in this era of primary care provider shortage-- greater job satisfaction for primary care providers.

These arrangements also incentivize medical groups to provide the right care, at the right time in the most cost-effective setting. For example, rather than trying to maximize FFS payments in high-cost settings, if appropriate, patients are safely and appropriately treated in lower cost settings, such as their home. In fact, the HCP experience is that patients have a strong preference to be treated in their homes (and other less-intensive settings) when it is safe and appropriate to do so.

Population-based payments also afford opportunities and incentives to address the environmental, social, and behavioral services that are often omitted in the fee-for-service context. For example, many of our patients need assistance with their mental health needs, commonly depression, in order to be able to truly improve their health status. Our approach takes into account all of these aspects of patient care.

To illustrate how the MA program translates into reality for patients, I will begin with an illustration of two patients, one in a coordinated care environment and one in a fee-for-service environment. In this illustration I focus on the care of two typical patients and I use cost inputs derived from the

standard ICD-9 codes and the current Medicare fee schedule. This illustration is fictional, but it is highly typical, and helps to show the greater efficiency and vastly better patient experience in Medicare Advantage. I will then turn to a specific example from our own experience at HCP.

A. An Illustration of Coordination versus Fragmentation: Donna and Margaret

This illustration compares the care experience and cost for two senior patients, Donna and Margaret. Donna is enrolled in an MA plan and receives care from a coordinated care physician organization. Margaret is in a model with no care coordination, like Traditional Medicare. The table below shows the two patients that begin with the same chronic condition, congestive heart failure and the same two-day inpatient stay.

Beyond the striking cost disparity reflected in this illustration, I would like to focus on the disparity in the care experience and quality between the two models. While both patients are initially hospitalized with the same chronic disease at the same cost, their care experience drastically differs upon discharge from the hospital.

Margaret, who is in an FFS model like Traditiional Medicare, is discharged from the hospital without any real post-discharge planning. She might have paper instructions and she might be told to call her physician in a few days, but there is no infrastructure or staff in place to ensure this happens. As a result, Margaret requires an emergency room visit followed by multiple post-discharge complications, landing her back in the hospital multiple times.

In contrast, for patients, like Donna, in Medicare Advantage, upon discharge, a team would spring into action to ensure that her follow-up care is properly managed. A discharge planner would make her appointments with her cardiologist and primary care physician. Staff within the coordinated care model would call her with appointment reminders and ensure she was seen in a physicians' office within a set number of days. A pharmacist would reconcile the medications given to her in the hospital

with the medications she takes for her routine care – this is to ensure there are no complications or duplication that could be potentially life threatening.

As we continue with our two patients on their journey, you can see illustrated below that both women have a fall and suffer a knee contusion. In this instance their paths then diverge again. Margaret, who is in Traditional Medicare, goes to the emergency department. In contrast, Donna, in Medicare Advantage with a system of supports, calls her care manager or nurse call center, which is part of her coordinated care service team. The call center would direct her to the most appropriate site of care, where she can be seen quickly – in this case, urgent care. Following her visit to urgent care and treatment for her knee, the care team would again spring to action. Case managers would visit her home and ensure it was properly outfitted to prevent future falls. Donna would follow up with her primary care doctor and again with her cardiologist (who, aided by the physician group's electronic medical record, has not forgotten about the congestive heart failure that originally landed her in the hospital).

Margaret has no system in place to ensure that her home is safe when she returns. She falls again, this time breaking her hip and ending up in the hospital for three days, followed by a 10-day stay in a skilled nursing facility for treatment -- a fall and stay that potentially could have been prevented if her home had been properly outfitted for fall prevention.

For too many patients who interact with Traditional Medicare, the experience is like Margaret's. I ask you to think about the care your loved ones have received, or maybe even you have received. Medicare Advantage, and the coordinated care model it represents, offers a different, better model for patients and their families, and in particular for seniors.

Table 1: Donna and Margaret, Fragmented versus Coordinated Care

Margaret Hamilton	Traditional Medicare (No Care Coordination)	Donna Rodriguez	MA (with Care Coordination)
Congestive Heart Failure DRG 292/ 2-day length of stay (LOS)	$7,740.70	Congestive Heart Failure DRG 292/ 2-day length of stay (LOS)	$7,740.70
911 Ambulance	$475.52	Cardiology visit	$160.20
Cardiac Arrhythmia and Conduction	$6,180.29	Primary Care visit	$45.51
Congestive Heart Failure	$7,740.70	Primary Care visit	$221.60
Cardiology visit Primary care visit x 2	$60.20 $98.62	Cardiology visit	$120.82
911 Ambulance	$475.52	Fall/Knee contusion Urgent Care visit	$158.30
Fall/Knee Contusion Outpatient ED visit	$982.78	Primary Care visit	$45.41
911 Ambulance	$475.52	Primary Care visit	$45.41
Inpatient hospital – hip replacement DRG 469/LOS: 3 days	$26,083.77	Cardiology visit	$60.20
SNF- 10-day stay	$4,263.30		
Total	$54,576.92	Total	$8,598.05
Patient out-of-pocket	$10,200.00	Patient out-of-pocket	$1,600.00

A final point on the cost savings achieved in the coordinated care model. These savings accrue directly to the benefit of seniors. Cost savings are typically reinvested by physician groups in care programs that benefit the patient population – such as quality incentive programs for seniors, special care clinics for the frail elderly, or electronic medical records to better monitor patients. In Medicare Advantage, savings earned by physician groups are reinvested directly into treating seniors.

B. HealthCare Partners' Team-Based Approach to Population Management

HCP has allocated its resources to implement a variety of programs that are tailored to the unique health status of our population. Our process begins by stratifying our patients into appropriate segments according to the needs of the population. Risk stratification requires the support of a strong technology backbone for physician organizations along with disease registries that help track the

population. Strong, accurate, clinical data supports our ability to identify and manage our population – without that data, none of these processes would be able to function at the high level they do today.

Once the population is identified using our technological tools, HCP uses a system that divides the population into one of five levels depending on patient risk:

- Level 5: hospice/palliative care.
- Level 4: home care management for chronically frail seniors. Provides in-home medical and palliative care management by physicians, nurse care managements, and social workers.
- Level 3: high risk clinics. Provides intensive one-on-one physician, social worker, and case management for the high risk and/or post discharge population.
- Level 2: complex care & disease management. Provides whole person care enhancement for the population using a multidisciplinary team approach.
- Level 1: self-management & health education programs. Provides self-management for patients with chronic disease.

Patients are then matched to appropriate programs. As an example, for our Level 3 patients, HCP put in place a comprehensive care clinic ("CCC") program. The program is particularly designed for patients with complex care needs, those with multiple hospital admissions within a single year, or patients who frequently visit the emergency room or our urgent care centers. In many cases, these patients need more intensive time invested in their care needs. The needs of these patients go beyond what a primary care physician can provide in a typical office visit. The CCC provides the opportunity to work more closely with these patients and their families to address their total care needs.

After a hospitalization, for example, a patient will be identified for the CCC program. Upon discharge, the patient will visit the CCC where the patient will meet with a social worker, a pharmacist will address medication reconciliation, and the care team will provide additional information about community resources from which the patient may benefit. The CCC professionals will talk to the patient about advanced care planning, if a plan had not been completed prior to the visit. All of the information from CCC visits is packaged and shared back with both the primary care physician and the specialists

that are involved in treating the patient inside and outside of the CCC. This information is also shared with families, when appropriate.

The CCC program has shown impressive results. For example, the CCC program shows a 25% decrease in hospital days per thousand, 26% decrease in hospital admissions per thousand, and a 27% decrease in emergency room visits.

C. Results that are Replicated throughout the Coordinated Care Delivery System

While the CCC program is unique to HCP, the results that flow from properly structured payment incentives are not. Below is a chart showing a comparison of senior hospital days per thousand and senior admissions per thousand showing comparisons of the FFS population and the MA population.

Senior Hospitalization Statistics[1]

Region	Senior Hospital Days/1000	Senior Admissions/1000
Nation's Trailing Regions Medicare FFS	2,000-2,472	380-402
National Average Medicare FFS	1,897	352
California Average Medicare FFS	1,706	318
California Average MA HMO	1,174	250
CAPG's Elite Groups MA HMO	<800	<220

III. Patient Interest in MA is Growing Because of its Positive Results

MA enrollment has grown steadily over the past several years. Recent analysis by the Kaiser Family Foundation shows that 14.4 million Medicare beneficiaries enrolled in MA plans in 2013 – a nearly 30 percent increase over just three years.[2] Although nationally 28% of Medicare enrollees are enrolled in an MA plan, there is broad variation across geographies.[3] In many of the states where HCP

[1] CMS and SDI, compiled by Managed Care Digest (2012).
[2] Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, Medicare Advantage, 2013 Spotlight: Enrollment Market Update (June 2013), available at http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8448.pdf (accessed Nov. 29, 2013).
[3] *Id.*

operates, enrollment in MA is above 35 percent.[4] In Los Angeles, where HCP has a large portion of its patient population, enrollment in MA is above 40 percent.[5]

The benefits that flow to patients may be one explanation for the growth in enrollment over the years. Peer reviewed research has consistently shown that MA outperforms FFS Medicare. For example, MA patients are more likely to get preventive screenings, like mammograms, eye tests for diabetes patients and cholesterol screening.[6] MA beneficiaries have been shown to have lower rates of preventable readmissions than patients in FFS Medicare.[7]

Recent analysis has even shown that the benefits of coordinated care in MA may filter out to the rest of the healthcare system. In some circles it has been described as a halo or spillover effect, where benefits of coordinated care sufficiently improve physician practices such that even patients not enrolled in MA see the benefits of coordinated care.[8] The study showed that a 10% increase in MA penetration is associated with a 2.4%-4.7% reduction in hospital costs for other patients.[9]

Surveys of Medicare beneficiaries have shown that seniors are highly satisfied with the MA program. A recent research survey showed that 94% of beneficiaries are satisfied with the quality they receive in MA and 90% of beneficiaries are satisfied with the benefits received in their MA plan.[10]

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[4] *See id.*

[5] Centers for Medicare & Medicaid Services, October 2013 Enrollment Data, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html?redirect=/MCRAdvPartDEnrolData/01_Overview.asp (accessed Nov. 29, 2013).

[6] Ayanian, John Z. Landon, Bruce E. Newhouse, Joseph P. et. all. *Medicare Beneficiaries More Likely To Receive Appropriate Ambulatory Services In HMOs Than In Traditional Medicare.* Health Affairs 32. no. 1228-1235. July 2013/

[7] Lemieux, Jeff, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. "Hospital Readmission Rates in Medicare Advantage Plans." *American Journal of Managed Care.* February 2012. Vol. 18, no. 2, p. 96-104.

[8] Baicker, Katherine. Chernew, Michael. Robbins, Jacob. *The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization.* National Bureau of Economic Research. May 2013.

[9] *Id.*

[10] North Star Opinion Research. "National Survey of Seniors Regarding Medicare Advantage Payments February 6-11, 2013."

Notably, the MA program has been particularly popular among low-income and minority beneficiaries.[11] 41 percent of Medicare beneficiaries with MA had incomes of $20,000 or less.[12] 64 percent of minority beneficiaries enrolled in MA in 2010 had incomes of $20,000 or less; 64 percent of African American and 82 percent of Hispanic MA beneficiaries had incomes of $20,000 or less.[13] In urban areas, like Los Angeles, low-income beneficiaries rely on this program because of the comparatively low out-of-pocket spending and robust health benefits associated with the program. In addition, all MA plans have an out-of-pocket maximum, a protection that is not offered in the FFS program. This helps protect beneficiaries from catastrophic expenses that threaten seniors' financial security. Downward pressure on the MA program increases the chance that these beneficiaries will face higher cost sharing and will make the program a less attractive option.

IV. MA is Under Stress – Death by a Thousand Cuts

Despite the positive impact of the MA program, the MA program is under severe stress due to a number of cumulative cuts to the program which, taken together, are having a dramatic and deleterious effect on physician groups in MA. I am concerned that these cuts could have the effect of pushing seniors away from MA and into a fragmented FFS delivery model. And, I think these cuts may drive many physician groups out of the program.

Below is an overview of the various legal and regulatory cuts imposed on the MA program. Many of these cuts were aimed at the health plan– that is, a direct reduction to the amount CMS pays to the health plan. However, I want to underscore that these cuts in most cases flow through directly to the amount the plan pays to physician organizations that are contracted to receive a percent of the premium. These cuts have been implemented without any corresponding decrease in physician group

[11] America's Health Insurance Plans, Low Income and Minority Beneficiaries in Medicare Advantage Plans, 2010 (May 2012).
[12] *Id.*
[13] *Id.*

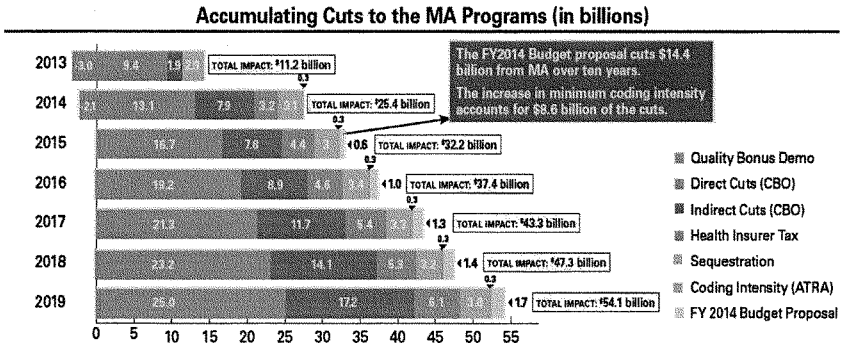
responsibilities, or any reduction in benefit levels. It is incredibly important to consider the total impact to physician organizations and patients that flow from the combined impact of these cuts.

A. Cuts in Existing Law and Regulation

The following series of cuts have already been legislated or regulated. The phase-in of the MA benchmarks alone was intended to bring MA payments to parity with Traditional Medicare. On top of that parity provision are layered additional legal and regulatory provisions that cut deeply into the MA program structure – at the health plan, physician organization, and beneficiary level. Below are the cuts and estimated percentage reductions associated with each:

- **Phase-in of Reduced MA Plan Benchmarks.** The Affordable Care Act revised the methodology and reduced the benchmarks for plan payments. The reductions were designed to bring funding for MA more closely in line with FFS costs by county. The phase-in of these reductions began in 2012 and continues through 2017. The impact of these changes varies by county, but urban counties, like Los Angeles, are particularly hard hit by this provision. *Estimated reduction: -2.0% (varies by county).*
- **Coding Intensity Adjustment.** Existing law requires that the Centers for Medicare & Medicaid Services (CMS) increase the coding intensity adjustment on MA plan payments beginning in 2014. This adjustment will reduce MA payments to account for differences in disease coding patterns between MA and FFS Medicare. *Estimated reduction: -1.5%*
- **Risk Adjustment.** CMS has discretion in selecting the risk adjustment model it uses to adjust payments to health plans based on the conditions of the patients. In 2013, CMS announced that it would implement significant changes to the risk adjustment methodology. This new methodology is being phased in over two years. The impact of these changes on physician organizations varies depending on the patient population the group serves. *Estimated reduction: -2.2% (varies by plan and physician organization)*
- **Sequestration.** Mandatory across-the-board spending cuts resulting from sequestration result in a two percent reduction to plan payments. *Estimated reduction: -2.0%.*
- **Insurer Tax.** MA plans are required to pay an annual fee to offset the cost of the ACA's coverage expansion. In some instances, this tax is passed through to physician organizations. *Estimated reduction: 1.9 to 2.4%.*

The table below shows the accumulating effect of these cuts to the program:[14]



Quality Bonus Demo reflects CMS estimates described in April 2012 GAO Report. CBO estimates of direct and indirect cuts from March 2010 score of the ACA and includes ACA coding intensity provisions. ATRA Coding Intensity/Indirect Cuts estimate reflect CBO score of 2013 fiscal cliff bill. FY2014 Budget Proposal includes CBO estimates of Coding Intensity and MA Employer Group proposals. Premium tax and sequestration figures from AHIP estimates based on CBO May 2013 Baseline and other sources.

The planned cuts may have the most deleterious effect on Special Needs Plans, a program within Medicare Advantage. These Special Needs Plans (SNPs) were created to improve care for some of the highest risk and sickest Medicare beneficiaries. SNPs are plans that provide benefits tailored to meet the needs of specific patient groups. Congress created the program in law in 2003 and has reauthorized the program multiple times since then. Over 500 SNPs provide care to over 1.5 million Medicare beneficiaries across the country.[15] These plans are a source of coordinated care for seniors with specific conditions and can be very valuable to high intensity patient populations, like those with end stage renal disease. Expiration of the SNP provision is yet another source of risk, instability, and

[14] America's Health Insurance Plans: Accumulating Cuts to MA Program Impact Beneficiaries (2013).
[15] Gorman Health Group, Time to Reauthorize Special Needs Plans (Sept. 2012) available at http://blog.gormanhealthgroup.com/2012/09/26/time-to-reauthorize-special-needs-plans/ (accessed Dec. 2, 2013).

unpredictability in the MA program. A long-term reauthorization of this program would stabilize care for patients that rely on SNPs.

B. 5 Star Quality Program

In 2013, there have been two significant mitigating factors that have prevented some physician organizations from feeling the full impact of MA program reductions. The first is the 5-star quality program, which has been tremendously successful in driving quality at the physician and health plan level.

Under existing law, plans that receive 4 or more stars out of 5 stars from the health plan quality rankings will receive bonus payments beginning in 2012. In addition, an existing CMS quality demonstration expanded the quality incentive program to plans with 3 or more stars and expanding the size of the bonuses. In the 5-star quality program, plans receive a single summary score rating on a scale of 1 to 5. A 5-star rating is the highest. The quality measurement program looks at how often enrollees get preventive care (screenings, tests, vaccines); management of chronic conditions; health plan responsiveness; health plan member complaints and appeals; and health plan customer service.[16]

We are now headed into the final year of the CMS demonstration with many observers citing evidence that the quality program is driving significant improvements: 52 percent of plans are now at 4 stars, up from about 37% of plans; and there are now 16 5-star rated plans.[17] The star ratings program has been an effective tool in driving improvements at the health plan and physician group level.

C. Congressional Leadership Leads to Improved Base Blended Rate

The second mitigating factor was a modest improvement in the regulatory notice that sets rates for health plans at the administrative level. During last year's Medicare Advantage rate setting process,

[16] CMS, 5-Star Plan ratings, available at http://www.cms/gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2013-5-Star-Enrollment-Period-Job-Aid.pdf (accessed Nov. 29, 2013).
[17] Gorman Health Group, Reading the Stars in Medicare in 2014-2015 (Oct. 24, 2013) available at http://blog.gormanhealthgroup.com/2013/10/24/reading-the-stars-in-medicare-in-2014-2015/ (accessed Nov. 29, 2013).

CMS proposed a significant additional reduction to MA payments. CAPG would like to thank the over 160 Members of Congress, including many on this Subcommittee, for your leadership on this issue. As many of you know, CMS ultimately did not finalize the additional reduction in the rate notice last year. We appreciate the support of Members of Congress in this effort to provide greater stability in the MA program. However, we know that the work is not done and we look forward to continuing to work with you in the future to preserve and strengthen the MA program.

D. Net Reductions to MA and Physician Organizations

The net effect of these payment policies has been significant downward pressure on payment to physician organizations. As described above, there is significant variation depending on geographic location and population risk. Across HCP, we experience top line revenue reductions in MA ranging from 6 to 9 percent from 2013 to 2014. I am very concerned that 2015 and beyond may pose an even bleaker financial picture. As described above, these legal and regulatory changes are phased in over a series of years, with their full impact not being realized until 2017. According to the Coalition for Medicare Choices, only about 10 percent of the already slated cuts to the MA program have taken effect.[18] This landscape, along with the potential for future cuts to MA, produces a great amount of uncertainty for physician organizations and beneficiaries.

V. Conclusion – The MA Program Should Be Strengthened, Not Cut

A number of challenges, both specific to Medicare and the broader fiscal climate, remain ahead. As Congress considers major policy objectives, like funding government programs, the debt ceiling, and reforming the sustainable growth rate formula, I am concerned that MA could again become a target of cuts to pay for such policies. I encourage lawmakers to consider the full picture of existing cuts, many of which have not fully unfolded at this time. I ask that Congress refrain from making further blunt cuts to the MA program. Instead, I respectfully request that you consider ways to encourage greater care

[18] Coalition for Medicare Choices, http://www.medicarechoices.org/How-Health-Reform-Law-Impacts-MA accessed Nov. 29, 2013.

coordination delivered by physician organizations, including the expansion and extension of eligibility in the 5 star quality program. The more that we can root out fee-for-service and its flawed incentives, the greater the chance of improving outcomes for seniors and achieving a financially stable Medicare delivery system. I believe there are some real opportunities to drive these types of incentives across the Medicare program, but additional cuts to MA are not compatible with that goal.

As Congress considers various ways to improve Traditional Medicare, whether it is through existing delivery system reforms (e.g., accountable care organizations, duals demonstrations), or through a reform of the sustainable growth rate formula, the role of MA as the backbone of coordinated care should not be ignored. MA provides a foundation on which the rest of the delivery system can build coordinated care. For example, physician organizations with the capability to accept two-sided risk arrangements, in most cases, have the experience required to be successful because of MA. Furthermore, many organizations that have been successful in deploying care coordination techniques in Traditional Medicare have leveraged off of their Medicare Advantage care processes and infrastructure to effectively do so. Chipping away at the MA program will undermine efforts to make progress in Traditional Medicare.

Instead of cutting MA, Congress should develop policies that encourage population-based payments to physician organizations in MA and in Traditional Medicare. This means encouraging the organized practice of medicine; strengthening the coordinated care infrastructure; providing incentives for team-based care and primary care; encouraging physician organizations to develop the ability to accept two-sided risk arrangements. There are existing efforts underway to encourage these types of arrangements, like accountable care organizations and the duals demonstration projects. Congress should keep a watchful eye on these demonstrations to ensure they are appropriately moving toward the goals of coordinated care outlined above.

Thank you for the opportunity to speak to you today. As the Subcommittee continues to consider important Medicare and fiscal policy in the future, I hope you will consider all that the Medicare Advantage program has to offer for seniors. Additional cuts to this program would further undermine the care processes that physician organizations have put in place and will have damaging consequences for the coordinated care model. I am happy to provide additional information.

Mr. PITTS. The Chair thanks the gentleman, and now recognizes Ms. Gold 5 minutes for summary of her opening statement.

STATEMENT OF MARSHA R. GOLD

Ms. GOLD. Hello. Thank you, Chairman Pitts, Ranking Member Pallone and members of the subcommittee to talk to you about Medicare Advantage.

As a Senior Fellow at Mathematica for the past 20-plus years, I have been examining Medicare Advantage for a long time, analyzing trends and plan participation, enrollment and benefits, looking at market dynamics and studying the implications for beneficiaries, working with the Kaiser Family Foundation and others.

My testimony today makes three points that I hope will inform the Congressional debate on the Medicare Advantage program today. My independent findings, I should say, in general are closely aligned with the positions and opinions expressed by MedPAC.

First and foremost, and we have heard this in a few other places here today, the MA program is strong with rising enrollment and widespread plan availability that is expected to continue through 2014, despite the concerns that the cutbacks in payment would discourage plan participation or make plans less attractive. There is 15 million people in the program, 29 percent of all benefits an all-time high, although it varies a lot across the country, and I think it is important to recognize that health care is local and the circumstances are different. The kind of care Dr. Margolis mentions happens in some places and not others.

Second, despite concerns over plan terminations in 2014, there are almost as many new plans entering in 2014 as terminating, and since the ACA was enacted, average in premiums to enrollees have declined, and they will still be lower in 2014 than they were in 2010. Exit and entry are essential characteristics of a competitive market. Medicare beneficiaries today have an average of 18 Medicare Advantage choices as well as the option to stay in the traditional Medicare program and with or without a supplement. Medicare beneficiaries can keep their plan. It is called Medicare, whether you are in Medicare Advantage or Medicare traditional.

It is difficult to see the rationale on a national basis for paying private plans more than Medicare currently spends on the traditional program, particularly when there is so much concern with the deficit and debt. Medicare has historically aimed to set payments to MA plans below or equal to what Medicare would expect to pay in the traditional program for beneficiaries who enroll in the plans. This changed in 2003, and by 2009, payments were considerably higher than Medicare would have paid for the same beneficiaries if they were in the traditional program. This costs every beneficiary more in added Part B premiums and it provides little incentive for MA plans to become more efficient. When I examined the 2009 plan bid data, I found wide variation in MA plans' costs relative to traditional Medicare spending, even controlling for plan types and payment levels. That suggests there was room for a lot more efficiency in the program variable across plans, and the policy changes that were in the ACA reflect recommendations that Congress's own Medicare Payment Advisory Commission has advocated for years.

Third, many of the concerns raised about 2014 offerings from what I have looked at are not consistent with evidence or inherent part of the way competitive markets work, and they are already addressed by protections in place in the program. Only 5 percent of enrollees in 2013 will have to shift plans. Most will be able to stay in the same type of plan. The average premium was down 21 percent from between 2010 and 2013 for a beneficiary, and premiums were stable in 2014. Some beneficiaries will see their premiums rise in 2014 but they will still be paying less than 2010, and if historical patterns hold, some of the beneficiaries will switch around so that they can get a better deal.

Clearly, payment reductions can discourage plans from participating in Medicare Advantage but this doesn't yet appear to be an issue, and Medicare has a number of protections for this such as network adequacy and quality standards, required notice of change in plans and provider networks and other means. Because MA choice is voluntary, there is also the option to return to traditional Medicare.

In its March 2013 report to Congress, MedPAC concluded that the payment changes under the Affordable Care Act have improved the efficiency of the program and may have encouraged plans to respond by enhancing quality, all the while continuing to increase MA enrollment through plans and benefit packages that beneficiaries find attractive. I believe my analysis and testimony is consistent with MedPAC's conclusion.

Thank you for your time, and I look forward to any questions.

[The prepared statement of Ms. Gold follows:]

MATHEMATICA
Policy Research

Marsha R. Gold
Senior Fellow
Mathematica Policy Research

Testimony for Hearing on
Medicare Advantage

Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives

December 4, 2013

Thank you, Chairman Pitts, Ranking Member Pallone, and members of the subcommittee for the opportunity to testify on Medicare Advantage. As a senior fellow at Mathematica Policy Research for the past 20+ years, I have tracked the history of managed care plans in Medicare; analyzed trends in plan participation, enrollment, and benefits; examined market dynamics in Medicare Advantage (MA); and studied the implications of MA for beneficiaries. This body of work extends from the late 1990s, when Medicare+Choice replaced the Medicare risk contracting (HMO) program, through today's mature Medicare Advantage (MA) program which I have been tracking with staff at the Kaiser Family Foundation as well as others. I have written and presented extensively on this work and its implications for policy development.

Medicare is critical to the well-being of the nation's seniors and people with disabilities, many of whom have low to moderate incomes, complex health care needs, and other characteristics that leave them disproportionately vulnerable. (The Henry J. Kaiser Family

Foundation 2011). The participation of private plans in Medicare, such as MA, has expanded the coverage alternatives available to Medicare beneficiaries, but the role that such plans should play remains controversial. My testimony today makes three key points about today's MA program that I hope will inform congressional debate on Medicare Advantage today.

First, the MA program is strong. Rising enrollment and widespread plan availability are expected to continue into 2014 despite concerns that cutbacks in payments to plans would discourage them from participating or make them less attractive to potential enrollees.

Second, MA plans are still paid more for an enrollee than a similar beneficiary would cost in the traditional Medicare program.. In considering future policy changes, it is difficult to see the rationale on a national basis for paying private plans more than Medicare now spends on the traditional program, particularly when there is so much concern about the federal deficit and debt.

Third, while some argue that changes in the MA market in 2014 should raise policy concerns, my recent analysis of offerings suggests that the market remains attractive to those sponsoring health plans and beneficiaries enrolling in them.. From my perspective, many of the concerns raised about 2014 offerings, which are either inconsistent with the evidence or an inherent part of the way competitive markets work, are already addressed by protections in place in the Medicare program.

In its March 2013 Report to Congress, the Medicare Payment Advisory Commission (MedPAC), a nonpartisan commission established in 1997 to advise Congress on Medicare, concluded that payment changes under the Patient Protection and Affordable Care Act of 2010 (ACA) have improved the efficiency of the program and may have encouraged plans to enhance quality—all while continuing to increase MA enrollment through plans and benefit packages that

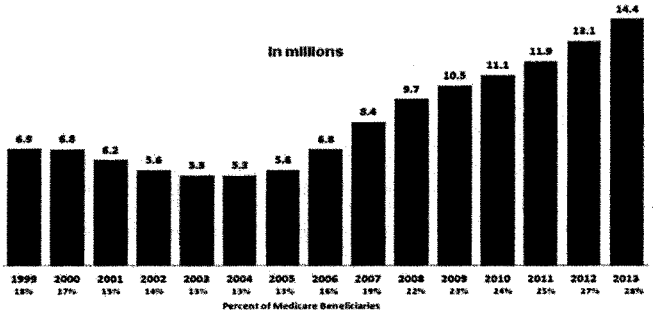
beneficiaries find attractive. I believe my analysis and testimony are fully consistent with the thrust of MedPAC's conclusions and its advice to Congress.

MA Enrollment Continues to Grow

For many decades, Medicare has offered beneficiaries access to popular private plans through a variety of legislative mechanisms including cost contracts (1970s); the Medicare risk contracting (HMO) program (1982); Medicare+Choice, which added even more private options (1997), and Medicare Advantage (2003), which expanded these options and integrated the new Part D benefit (Gold 2001, 2008). Enrollment in these plans has historically ebbed and flowed as payment levels have fluctuated, but they were never meant to replace traditional Medicare (PL 105-33). In fact, more than 70 percent of beneficiaries are covered under traditional Medicare.

The ACA (PL 111 148 PART III) sought to scale back payments to MA plans in order to more closely align them with payments made for beneficiaries in the traditional program—as long changes like this were recommended by MedPAC (MedPAC 2009). Because MA payments are drawn from both the Medicare Trust Fund and Part B, reducing these payments also helped to extend the life of the Medicare Trust Fund and slowed increases in Part B premiums for all beneficiaries. Despite concerns that the cutbacks (which began in 2012) could hurt the MA program, enrollment has continued to grow (Exhibit 1). More than 15 million Medicare beneficiaries were enrolled in MA as of November 2013—an all-time high of 29 percent of all Medicare beneficiaries (CMS 2013). And despite concerns that MA plans would leave the market in 2014, there are almost as many new plans entering as leaving (Exhibit 2). Since the ACA was enacted, average premiums paid by enrollees have declined and will be even lower in 2014 than they were in 2010, as discussed later.

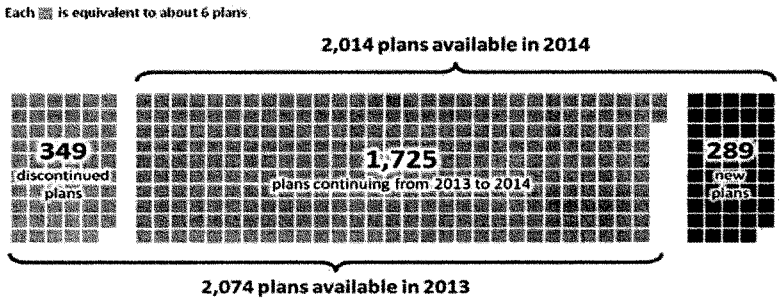
Exhibit 1: Total Medicare Private Health Plan Enrollment, 1999-2013



Note: Includes cost and demonstration plans, and enrollees in SNPs as well as other MA plans.

Source: Mathematica/Kaiser Family Foundation analysis of CMS MA enrollment files, 2000-2013; Mathematica, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 2001-2007, enrollment numbers from March of the respective year, except for 2006, which is from April.

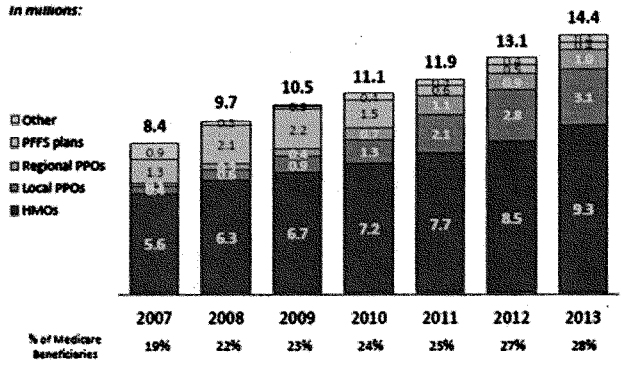
Exhibit 2: Number of Medicare Advantage Plans Available, by Plan Availability Status, 2013 and 2014



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites).
SOURCE: MPR/KFF analysis of CMS's Landscape Files for 2013 – 2014.

New types of private plans, such as preferred provider organizations (PPOs)—which give beneficiaries broader access to providers and generally cost more that HMOs—have accounted for a disproportionate share of recent growth, although the majority of enrollees have remained in HMOs, the core of the original predecessor programs to Medicare Advantage.(Exhibit 3).

Exhibit 3: Total Medicare Advantage Plan Enrollment, 2007-2013



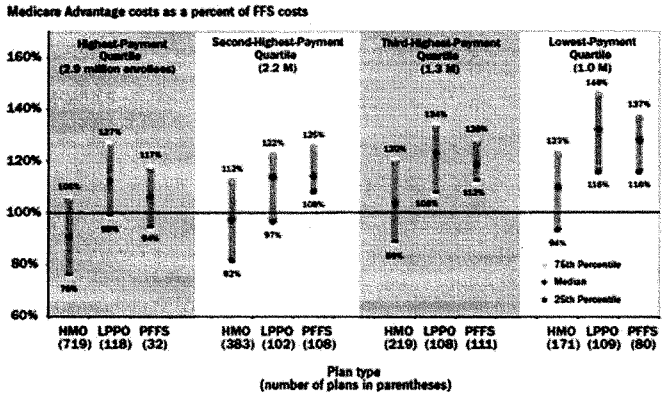
Recent Cutbacks in MA Payments Relative to Traditional Medicare Are Equitable

Medicare has historically aimed to set payments to private plans below or equal to what it paid in the traditional program for a similar beneficiary in the same county as the MA beneficiary. Payments in the Medicare risk-contracting program were originally set at 95 percent of traditional program payments, but weaknesses in the risk adjustment method—which have since been fixed--pushed the payments considerably higher (Brown et al. 1993). When the risk program evolved into Medicare+Choice, the link between private-plan and traditional-program payments was modified in a subset of counties for two reasons: to support growth in areas with few, if any, private plans ("floor counties") and to address geographical differences in payment

("blend counties"). These changes did not have the intended effect of growing the program enrollment, in part because annual costs in the traditional program were growing more slowly during that period than in the past, which contributed to low rates of annual increases in premiums (Berenson 2008). As a result, many private plans withdrew from the market (Gold 2001; Gold et al. 2004). In 2003, Congress sought to stabilize the program—now termed "Medicare Advantage—by setting the minimum payment rate at 100 percent of fee for service (FFS) and, more critically, by providing an option that allowed annual premiums to increase at a substantially higher rate (Gold 2008).

Over time, these cumulative policy changes led to MA plans being paid considerably more than Medicare would pay for a similar beneficiary in the traditional program, despite the improvement in risk adjustment to account for favorable selection. In 2009, for example, MedPAC estimated that the MA payment benchmark (the most Medicare would pay a plan), was, on average, 118 percent of what Medicare would spend for a similar beneficiary in the traditional program. Furthermore, MA payments (legislatively set at 75 percent of MA benchmarks, up to plan costs) were 114 percent of traditional Medicare spending. Thus, MA has been paid considerably more than Medicare pays for similar beneficiaries in the traditional program.

Exhibit 4: Comparison of Medicare Advantage Plan Bid Costs to Medicare Fee-for-Service Costs, by Geographic Payment Quartiles, High to low, 2009



Notes: FFS = fee-for-service; HMO = health maintenance organization; LPPO = local preferred provider organization; PFFS = private fee-for-service.
Source: Mathematica analysis of publicly available Medicare Advantage data.

The data on which these estimates are based have not historically been available to the public, but a recent analysis based on information made available through a Freedom of Information Act request produced similar results and highlights the geographical variation in payments relative to traditional Medicare (Biles et al. 2011). My own analysis of these data points to wide variation in MA costs relative to traditional Medicare both within and across the two types of plans even controlling for payment levels (Exhibit 4), suggesting that there is room for greater efficiency in how care is delivered (Gold 2013; Gold and Hudson 2013).

For many years, MedPAC (2010) has recommended that Congress align payments to MA plans with payments to traditional Medicare, and the ACA's provisions are gradually working toward this goal. MedPAC (2013) found that the average benchmark for payments to MA plans dropped to 110 percent of traditional program spending, down 8 percent from the 2009 level, and

Exhibit 5: Projected Payments Exceed FFS Spending for all Plan Types in 2013

Plan type	Percent of PFFS spending in 2013		
	Benchmarks	Bids	Payments
All MA plans	110%	96%	104%
HMO	110	92	103
Local PPO	111	107	108
Regional PPO	106	97	102
PFFS	110	105	107
Reached availability plans included in totals above			
SNP*	111	96	105
Employer groups*	111	106	108

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider fee-for-service), SNAP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans. We estimate FFS spending by county using the 2013 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made ot teaching hospitals

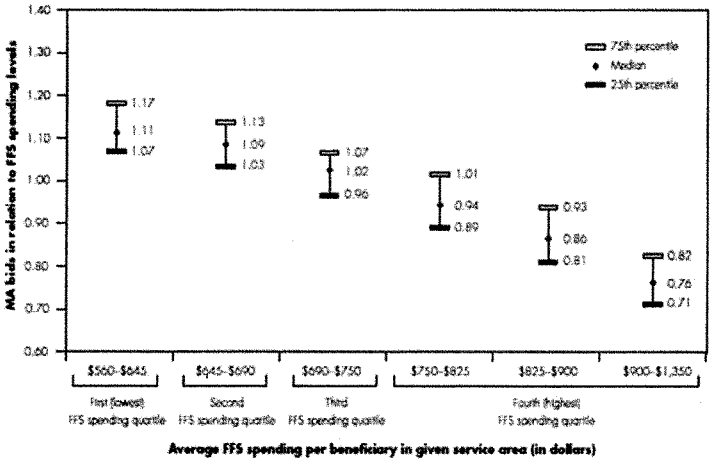
*SNPs and employer group plans have restricted availability and their enrollment is included in the statistics by plan type. We have broken them out separately to provide a more complete picture of the MA programs.

Source: MedPAC analysis of date from CMS on plan bids, enrollment, benchmarks, and FFS expenditures.

the average payments themselves dropped to 104 percent (Exhibit 5). Meanwhile, average bids—that is, what MA plans estimate it will cost them to provide the Medicare Part A and B benefit (which were historically above 100 percent of costs in the traditional program)—have fallen to 96 percent of traditional program spending. However, this average is due to HMO experience (They are the only plan type that averages below traditional program spending.) There also is considerable variation across plans and geographic locales. HMOs have not, however, proven viable in all markets, as their growth has been constrained by the reluctance of many beneficiaries' to have a limited choice of providers. Local PPOs, which offer more provider choice but also cost more and represent a rapidly growing part of the program, had bids that were, on average, 108 percent of traditional program spending. In examining these data, MedPAC (2013, p. 298) found that even if there were no quality bonuses or favorable selection, plans in 2013 would still have received about 101 percent of the amount Medicare spends on similar beneficiaries in the traditional program. MedPAC also found that the efficiency of MA

plans has continued to vary, although MA spending perhaps did not vary as much across geographic areas as it did in the traditional program (Exhibit 6).

Exhibit 6: Medicare Advantage Bids in Relation to FFS Spending Levels, 2013



Source: Medicare Payment Advisory Commission "Chapter 13: The Medicare Advantage Program: Status Report," in Report to the Congress: Medicare Payment Policy, March 2013.

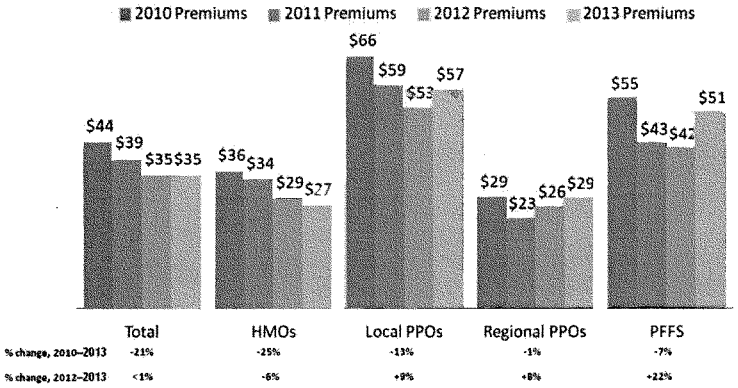
Implications for Beneficiaries

Beneficiaries continue to have good access to private MA plans (Gold et al. 2013b). In 2012, the average beneficiary could choose from among 18 local MA plans (This estimate excludes plans with unique enrollment requirements such as special-needs plans (SNPs). Companies that are terminating plans often are adding other plans in that same market (Exhibit 2). Plans leaving the market are disproportionately private fee-for-service plans, a trend based on changes predating the ACA. Only five percent of MA enrollees in 2013 will have to switch plans for 2014 because their plans will no longer available. However, most who do will be able to enroll in the same type of plan, often offered by the same company.

Despite the decline over the past few years in MA payments relative to costs under traditional Medicare, plans also have been able to keep premiums down in order to attract enrollees (Exhibit 7). From 2010 through 2013, the average MA enrollee's premium dropped by 21 percent—25 percent if they were in an HMO (Gold et al 2013a). Average plan premiums will be stable in 2014, although once current enrollment patterns are factored in, enrollees will see their premiums rise by an average of 5 percent, assuming that they stay in the same plan in 2014 (Gold et al 2013b). If historical patterns hold, some enrollees may decide switch plans to keep premiums down. However, even if they stay put, MA enrollees will be paying less, on average, in 2014 than they did in 2010.

Benefits also remain attractive, even though out-of-pocket spending can be high, given the limited income and assets of Medicare beneficiaries, particularly if they have complex health needs that persist from year to year (Cubanski et al 2011). In 2013, 47 percent of all MA

Exhibit 7: Weighted Average Monthly Premiums for Medicare Advantage Prescription Drug Plans, Total and by Plan Type, 2010-2013



Note: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). Includes only MA plans that offer Part D benefits. The total includes cost plans (not shown separately). The premiums for a subset of sanctioned plans were not available in 2011. These plans were excluded from this analysis.

Source: Mathematica/Kaiser Family Foundation analysis of CMS Landscape Files for 2010–2013 and March Enrollment Files for 2010-2013.

enrollees were in plans in which the out-of-pocket limit was above CMS's recommended $3,400 limit, and 24 percent were in plans with out-of-pocket limits over $5,000 (Gold et al. 2013a). Such limits attract beneficiaries because they provide more financial protection but the amount of the limit rose from 2012 to 2013 and appears to be poised to rise again in 2014 (Gold et al 2013b). In a competitive market, it is important for beneficiaries to carefully examine differences in cost sharing across plans and how they change from year to year if they are to choose a plan that is best for them whether that be a Medicare Advantage plan or traditional Medicare, with or without a Medigap supplement.

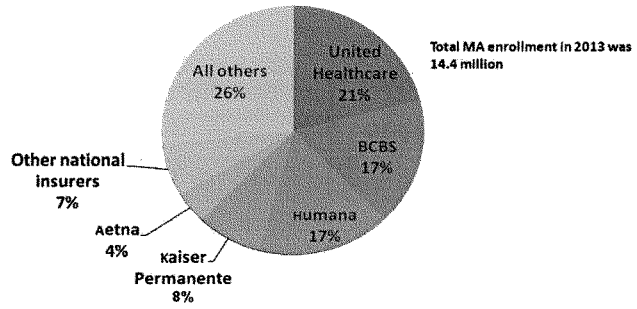
Implications for Policy

The history of private plans in Medicare makes it clear that payment reductions can discourage plans from participating in MA (Gold et al 2004, 2011a), but this does not yet appear to be an issue. Whether it should be--if circumstances change--depends on one's perspective on the desirability of choice, even if it costs (rather than saves) money. MedPAC (2013) sees signs that payment changes are encouraging plans to take steps to become more efficient. The downside, of course, is that some of these changes may not always be popular with beneficiaries or with providers (Gold 1999). Medicare seeks to protect beneficiaries from the adverse effects of such changes through mechanisms like network adequacy and quality standards, requirements about notifying beneficiaries of change in their plan and provider networks, and other means. And because enrolling in MA is voluntary, there also is the option to return to traditional Medicare during the annual open enrollment period (more often if they are dually eligible for Medicare and Medicaid).

The crucial policy question is how much additional Medicare spending to maintain the private option is justified if the traditional program can provide benefits for less than private plans can and if they can do so in a manner that is satisfactory to the vast majority of Medicare

beneficiaries who continue to choose the traditional program? Paying more for beneficiaries who choose a private plan, as a matter of policy, implies that one program is better than another—perhaps by offering better quality or more effective cost control. Unfortunately, the evidence has never consistently or strongly shown this to be the case, certainly not to the extent that would justify substantially higher payments to private plans (Gold 2003, 2012). It is particularly hard to justify excess payments in today's environment, in which there is concern about growing Medicare spending and its effect on the deficit and the national debt. Because MA enrollment is concentrated in a few firms, higher payments also involve a substantial transfer of public funds to these firms (Exhibit 8). Under the ACA, both traditional Medicare and MA are encouraged to take steps to become more efficient. Further, traditional Medicare remains popular with beneficiaries, which means that paying more for private plans is effectively a tax on their choice because their Part B premiums will increase, with no gain in benefits to them.

Exhibit 8: Medicare Advantage Enrollment, by Firm or Affiliate, 2013



Note: Other includes firms with less than 3% of total enrollment. BCBS are Blue Cross/Blue Shield affiliates and include Wellpoint BCBS plans that make up 4% of all enrollment (558,833 enrollees) in MA plans; approximately 47,000 beneficiaries are enrolled in other Wellpoint plans. Other national insurers includes 1,228,443 enrollees across the following firms: Cigna (438,252), Coventry (305,534), Wellcare (252,563), Universal American (127,340), Munich American Holding Corporation (57,697), and Wellpoint non-BCBS plans (47,007).

Source: Mathematica/Kaiser Family Foundation analysis of CMS Enrollment Files, 2013.

Conclusion

My independent research and analysis are consistent with MedPAC's conclusions in its March 2013 Report to Congress, in which it concluded that payment changes under the ACA have improved the efficiency of the Medicare Advantage program and may have encouraged plans to enhance quality—all while continuing to increase MA enrollment through plans and benefit packages that beneficiaries find attractive.

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Public Law 111-148 PART III—Improving Payment Accuracy of the Patient Protection and Affordable Care Act.

Public Law 105-33—The Balanced Budget Act of 1997. Part C: Medicare+Choice Program: Eligibility, Enrollment and Enrollment.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes Mr. Kaplan 5 minutes for summary of his opening statement.

STATEMENT OF JON KAPLAN

Mr. KAPLAN. Chairman Pitts, Ranking Member Pallone and members of the subcommittee, thank you for the opportunity to testify today.

My name is Jon Kaplan, and I am a Senior Partner of the Boston Consulting Group. I have a healthcare background that is over 25 years, working closely with both nonprofit and for-profit healthcare entities throughout the entire healthcare industry.

Earlier this year, I led a BCG team that analyzed the differences in health outcomes between patients enrolled in traditional Medicare and those enrolled in private Medicare Advantage health plans. We found that patients enrolled in the Medicare Advantage plans had better health outcomes than those participating in traditional Medicare.

There are three key findings from our research. First, the MA patients in our sample received higher levels of recommended preventive care and had fewer disease-specific complications. Second, during acute episodes requiring hospitalization, the patients in the MA plans spent almost 20 percent less time in the hospital than those in traditional Medicare. In addition, they had less readmissions into the hospital. Finally, the percentage of people who died in the year we studied was substantially higher in the traditional Medicare sample than those in the Medicare Advantage sample. This is a striking finding and one that we hope to explore further in a longitudinal, multiyear study.

Our study did not directly address the causes of these differences. In my experience, however, the key factor is MA itself and how the plans are organized and managed. First, these plans align financial incentives with clinical best practice. Second, they recruit the most effective providers and include only those who practice high-quality medicine. Third, they put a strong emphasis on active care management and invest resources in prevention to keep patients healthy, stable and out of the hospital.

There are many indications in our study that these three mechanisms are responsible for the better health outcomes of the MA patients. Take the example of diabetes. Two clinical standards for diabetes care are frequent HbA1c testing and regular screenings for kidney disease. Our data show that the MA sample had substantially higher number on both tests than in the traditional Medicare sample. This stronger focus on prevention helps keep patients healthy and avoids the need for highly disruptive and expensive acute care interventions. For example, we found that diabetic patients in MA had dramatically fewer foot ulcers and amputations than those patients in traditional Medicare.

Aligned incentives and active care management also helps explain lower utilization rates. Take the example of emergency room visits. In our traditional Medicare matched sample, about four out of ten of the patients visited the emergency room at least once per year. For many portions of Medicare Advantage, however, this figure drops to around two out of ten.

One last finding to share: Among the three types of MA plans that we studied, the very best health outcomes were for those patients in the capitated MA plan. The findings suggest that capitation is extremely effective at supporting provider investment and preventive medicine and active care coordination.

Let me conclude by suggesting some implications of our study for health policy. In my opinion, Medicare Advantage plans are an example of a successful public-private partnership. These plans represent an integrated care delivery model that uses effective provider incentives, real-time clinical information and care coordination capabilities to improve quality and lower cost. In my opinion, Federal policy should be supporting and not discouraging more Medicare patients to enroll in MA. Their health outcomes and the entire U.S. healthcare system are likely to be better as a result.

Thank you for inviting me to speak, and I look forward to answering your questions.

[The prepared statement of Mr. Kaplan follows:]

BCG

50 YEARS

Jon Kaplan
Senior Partner and Managing Director
The Boston Consulting Group
December 4, 2013
Energy and Commerce Committee, Subcommittee on Health
Hearing: "Medicare Advantage: What Beneficiaries Should Expect Under the President's Health Care Plan"

Written Testimony – ***Alternative Payer Models Show Improved Health-Care Value***

Chairman Pitts, Ranking Member Pallone and members of the subcommittee, thank you for the opportunity to testify today.

My name is Jon Kaplan, and I am a Senior Partner at The Boston Consulting Group (BCG). I have been a health care consultant for the past 25 years, working closely with both for-profit and not-for-profit entities throughout the industry, including managed care companies, hospitals, retail pharmacies, and pharmacy benefit managers.

Earlier this year, I led a BCG team that analyzed the differences in health outcomes between Medicare patients enrolled in traditional Medicare, who see doctors on a traditional fee-for-service basis, and patients who are enrolled in Medicare Advantage health plans provided by private insurers. We found that patients enrolled in Medicare Advantage plans had better health outcomes than those participating in traditional Medicare.

Before discussing our findings in more detail, I want to describe some distinguishing characteristics of our study. First, it had an unusually large sample size, including some 3 million Medicare patients. Approximately 1.3 million of these patients were in traditional Medicare and used providers on a traditional fee-for-service basis. The remaining 1.7 million were enrolled in one of three Medicare Advantage plans at a leading private insurer: either a preferred provider organization (PPO), a non-capitated HMO or a fully capitated HMO.

Second, our large sample size allowed us to reduce selection bias. We used two techniques to do so: statistical regression to risk-adjust our data and matched population to compare a subset of the patients who mirrored each other across a set of measured variables, including age and number of disease co-morbidities.

Finally, we vetted both our methodology and our findings with a number of leading academic health outcomes researchers before publishing it on our website and sharing it publicly.

Now let me describe briefly three high-level findings of our study:

- The Medicare Advantage patients in our sample received higher levels of recommended preventive care and had fewer disease-specific complications, such as the number of diabetic foot amputations and ulcers.

- During acute episodes requiring hospitalization, the patients in the Medicare Advantage plans spent about 19 percent less time in the hospital than those in our traditional Medicare sample – and yet, they also experienced a lower percentage of readmissions.

- Finally, the percentage of traditional Medicare patients who died during the year of our study was 6.8 percent, on a normalized basis. But the analogous single-year mortality of the patients in the Medicare Advantage sample was, depending on the plan, substantially lower: no higher than 2.8 percent and as low as 1.9 percent. This is a striking finding and one that we hope to explore further in a longitudinal, multiyear study.

Our study did not directly address the causes of these differences. In my experience, however, the key factor is Medicare Advantage itself and how the plans are organized and managed. First, these plans align financial incentives with clinical best practice. Second, they recruit the most effective providers and include only those who practice high-quality medicine. Third, they put a strong emphasis on active care management and invest resources in prevention to keep patients healthy, stable, and out of the hospital.

There are many indications in our study that these mechanisms are responsible for the better health outcomes of the Medicare Advantage patients. Take the example of diabetes. Two clinical standards

for diabetes care are frequent testing for glycated hemoglobin (known as HbA1c) and regular screening for kidney disease, which commonly results from poorly-controlled diabetes. Our data show that in 2011 the average number of HbA1c tests for diabetics in the traditional Medicare sample was less than one per patient. However, the average HbA1c tests in Medicare Advantage ranged from 1.26 to as many as 1.36 per patient. The average number of kidney disease screenings per Medicare patient was 0.17, versus at least 0.24 and as many as 0.40 per Medicare Advantage patient.

This stronger focus on prevention helps keep patients healthy and avoid the need for highly disruptive, and expensive, acute care later on. For a striking illustration of this fact, consider the following finding. The diabetic patients in traditional Medicare had an average of 11.5 amputations for every 1,000 patients. By contrast, the Medicare Advantage samples had no more than 1.1 and as few as 0.3. There were 212 foot-ulcer procedures for every 1,000 patients in Medicare, whereas Medicare Advantage had no more than 131 and as few as 25 per 1,000 patients.

Aligned incentives and active care management also helps explain lower utilization rates. Take the example of emergency room visits. About 4 in 10 of the patients in our traditional-Medicare matched sample visited the emergency room at least once in 2011. But for Medicare Advantage, this figure drops to between 2 and 3.

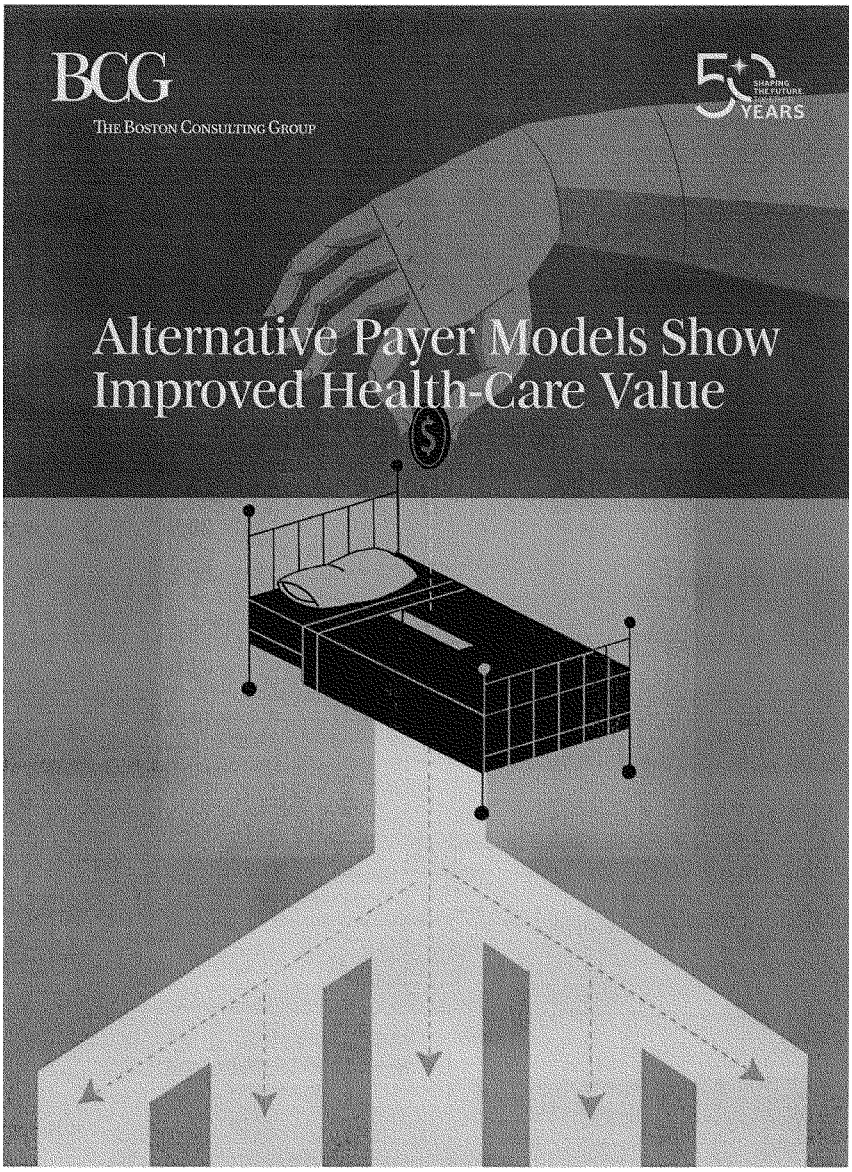
One last finding is also worth considering. Among the three types of Medicare Advantage plans that we studied, the very best health outcomes were for those patients in the *capitated* Medicare Advantage plan. Under capitation, primary-care physicians are paid a risk-adjusted, contracted rate for each member regardless of the number or nature of services provided. The findings suggest that capitation is extremely effective at supporting provider investment in preventive medicine and active care management.

Let me conclude by suggesting some implications of our study for health policy. In my opinion, Medicare Advantage plans are an example of a successful public-private partnership. These plans represent an integrated care-delivery model that uses effective provider incentives, real-time clinical data and analysis, and care-coordination capabilities to improve quality and lower costs.

Medicare Advantage plans also represent a proven model from which the entire system can learn. Insurers that provide Medicare Advantage are already in the marketplace, competing with each other every day to deliver cost-effective, quality care. What's more, they are in a unique position to team with the clinical community to bring about change. They have the scale, the broad access to data, years of experience learning what works in local marketplaces, and the flexible infrastructure to help innovate and improve health care delivery.

For these reasons, federal policy should be encouraging – not discouraging – more Medicare patients to enroll in Medicare Advantage programs. Their health outcomes – and the entire U.S. health care system – are likely to be better as a result.

Please refer to the BCG report "Alternative Payer Models Show Improved Health-Care Value" for additional findings in our study of the differential health outcomes for patients in traditional Medicare and in Medicare Advantage plans. The appendix to the report outlines the full research methodology and limitations of our study.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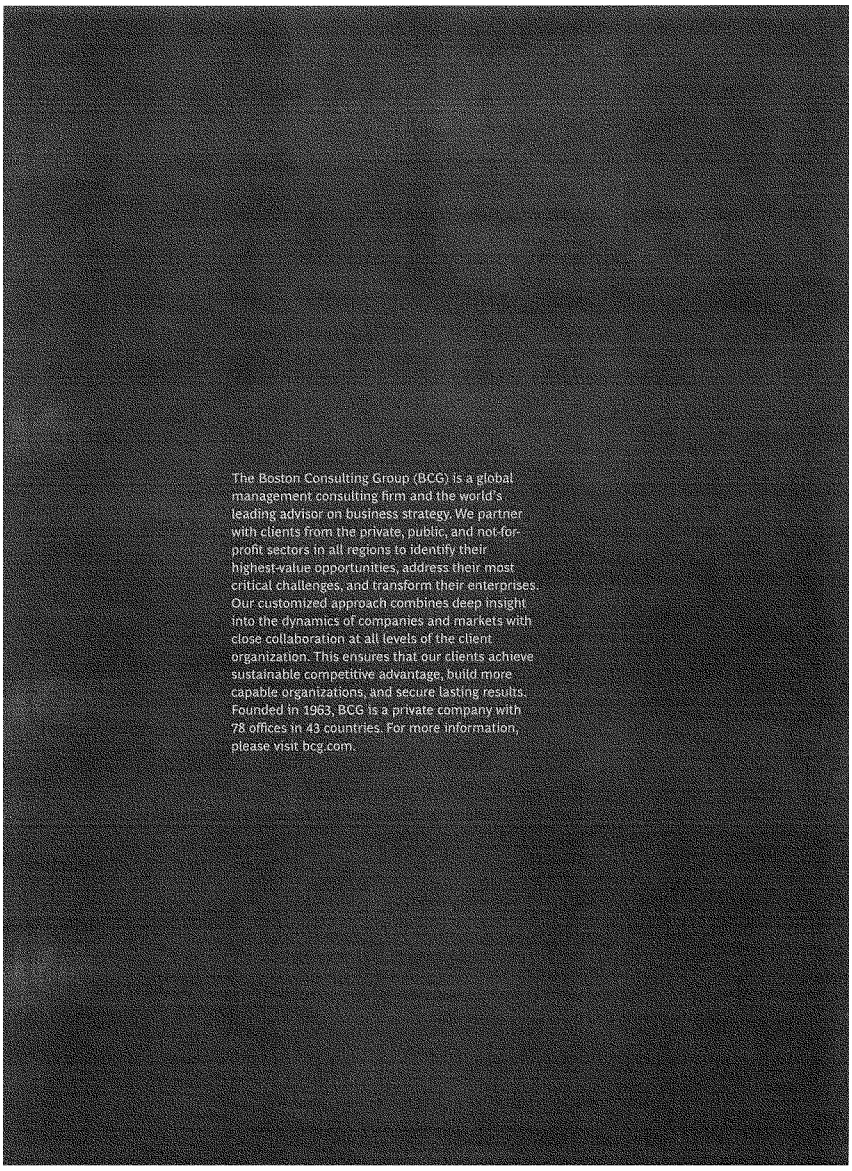
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Alternative Payer Models Show Improved Health-Care Value

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May 2013

AT A GLANCE

In their efforts to improve health care value, health systems around the world are experimenting with alternative models for care delivery and reimbursement. These alternatives take a more managed approach to care delivery than traditional fee-for-service medicine. Research has begun to suggest that they are successful at cutting costs. But what has been the impact of such plans on health care quality?

THE IMPACT OF ALTERNATIVE MODELS ON HEALTH CARE QUALITY

To find out, BCG analyzed claims data for some 3 million U.S. Medicare patients. We found that on three internationally accepted dimensions of health care quality—single-year mortality, recovery from acute episodes of care requiring hospitalization, and the sustainability of health over time—patients who were enrolled in more managed Medicare Advantage plans offered by private insurers had better outcomes than patients participating in Medicare on a traditional fee-for-service basis.

IMPLICATIONS FOR HEALTH CARE DECISION MAKERS

Our research demonstrates that more managed plans deliver better care than fee-for-service medicine and thus do a better job of improving health care value. Payers, providers, and policymakers worldwide have a lot to learn from the differences between fee-for-service and the alternative care-delivery models used in U.S. Medicare Advantage plans.

IN THE GLOBAL STRUGGLE to manage the cost of health care, payers, providers, and policymakers are increasingly focusing on value—that is, on improving outcomes while also maintaining or lowering costs.[1] To that end, health systems around the world are experimenting with a variety of alternative models for care delivery and reimbursement that differ from traditional fee-for-service medicine.

The U.S. health-care system offers a kind of "natural experiment" for evaluating the differential impact of some of these models on the cost and quality of care. The United States is one of the few countries that employ multiple payer models in parallel, and has done so for some time, making possible a real-world comparison of their impact on health outcomes and costs.

A case in point is Medicare, the government program that covers some 52 million Americans who are 65 and older or who suffer from chronic disabilities or end-stage renal disease. Roughly three-quarters of the Medicare-eligible population see doctors and other providers on a traditional fee-for-service basis, with the costs of the services reimbursed directly by Medicare. About a quarter, however, are enrolled in Medicare Advantage health plans provided by private insurers. These plans offer a more managed system of care delivery—for example, through preferred provider organizations (PPOs), health maintenance organizations (HMOs), capitated health networks, and other delivery models. Medicare pays the insurer a set amount per patient, and it is the insurer's responsibility to pay any claims.

Health systems around the world are experimenting with a variety of models for care delivery and reimbursement.

What distinguishes these Medicare Advantage plans both from traditional fee-for-service medicine and from one another is the degree to which they make use of three organizational mechanisms that are meant to encourage the delivery of cost-effective quality care: a selective network of providers, financial incentives that are aligned with clinical best practices, and active care management that emphasizes prevention in an effort to minimize expensive acute care.

Research has begun to suggest that these health plans are successful at cutting costs compared with fee-for-service medicine. One recent study, for example, found that utilization rates in some major categories, including emergency departments and ambulatory surgery or procedures, generally were 20 to 30 percent lower for patients enrolled in Medicare Advantage HMOs than for those with Medicare fee-for-service coverage.[2]

But what has been the impact of such plans on health care quality? In the past, there were widespread concerns, especially on the part of the general public, that cost savings came at the expense of quality of care. In the 1990s, for example,

HMOs came in for major criticism for denying medically necessary services to patients, ostensibly in order to control costs. And even today, the assumption that higher cost is synonymous with better quality remains widespread.[3]

Payers, providers, and policymakers can learn from the differences between fee-for-service and the alternative models used in Medicare Advantage plans.

To better understand this issue, The Boston Consulting Group recently analyzed claims data for some 3 million Medicare patients. We found that on three internationally accepted dimensions of health care quality—single-year mortality, recovery from acute episodes of care requiring hospitalization, and the sustainability of health over time—patients enrolled in Medicare Advantage plans had better outcomes than those participating in Medicare on a traditional fee-for-service basis. The Medicare Advantage patients had lower single-year mortality rates, shorter average hospital stays, and fewer readmissions. They also received higher levels of recommended preventive care and had fewer disease-specific complications.

Our findings demonstrate that the more managed plans do not compromise quality. Just the opposite: they deliver higher-quality care than fee-for-service medicine and thus do a better job of improving health care value. Payers, providers, and policymakers worldwide can learn a lot from the differences between fee-for-service and the alternative care-delivery models used in Medicare Advantage plans.

Breaking the Compromise Between Cost and Quality

In recent years, health care professionals and policymakers have come to understand that the relationship between cost and quality is rarely simple or straightforward. Spending more money does not necessarily deliver better care. The U.S. spends about 18 percent of GDP on health care every year (roughly $2.8 trillion), compared with about half that amount in other developed countries. And yet, in nearly every disease group tracked by the 34 countries constituting the Organisation for Economic Co-operation and Development, U.S. health outcomes are below the OECD median.[4] What's more, there is a growing realization that poor health-care quality can itself be hugely expensive. The overuse of medically unnecessary procedures is a large driver of rising health-care costs—responsible for as much as $750 billion per year.[5]

The Medicare Advantage plans we studied represent a fundamentally different health-care-delivery model from fee-for-service medicine. To varying degrees, they use three organizational mechanisms to lower costs while improving outcomes.

- *Selective Provider Networks.* Providers are part of a selective network created by the insurer, and patients are either encouraged or required to see only those providers who are part of that network. This selectivity allows the plans to recruit the most efficient and effective providers and to exclude those whose practices are high in cost and low in quality outcomes.

- *Financial Incentives Aligned with Clinical Best Practices.* In fee-for-service medicine, physicians are paid directly for the volume of services they provide—whether or not those services actually contribute to better outcomes. In Medicare Advantage plans, by contrast, covered services and the rates at which they are compensated are negotiated in advance and aimed at efficient, effective care delivery. Some providers are eligible for bonuses if they achieve certain quality and preventive-

medicine targets that enable the payers to receive reimbursement premiums from Medicare. The most comprehensive versions of these models often include a risk-sharing contract known as *global capitation,* in which providers are paid a set risk-adjusted annual fee per patient and are financially liable for any excessive spending but also able to benefit when they provide care at a lower cost.

- *Active Care Management.* Finally, and perhaps most important, there is a strong focus on active care management that invests resources in prevention in order to keep patients healthy, stable, and out of the hospital, thus avoiding as much as possible the higher costs of hospitalization required by acute episodes of care. Care management practices often include extensive services such as detailed analytics that preemptively identify at-risk patients (for instance, the chronically ill or recently discharged); remote vital-sign monitoring and regular communication with patients; disease management websites; and home visits from a multidisciplinary team of providers including registered nurses, physical therapists, and social workers. Such services are particularly important for chronically ill patients, who are a fast-growing segment of the population and increasingly expensive to treat if their health starts to decline.

To assess the impact on health quality of delivery models that use these mechanisms, BCG compared claims data and demographic information from 2011 for some 3 million Medicare patients. Approximately 1.3 million of the patients in our sample used providers on a traditional fee-for-service basis. The remaining 1.7 million patients were enrolled in private Medicare Advantage plans.

BCG compared claims data from 2011 for some 3 million Medicare patients.

About 1.1 million of the private-insurance patients were enrolled in a PPO. Of the insurance plans we studied, PPOs are the closest to traditional fee-for-service medicine. Although patients have an economic incentive to choose providers affiliated with the plan, they can go outside the plan's network if they choose to by paying a higher copayment or coinsurance. Providers are still paid for each service they provide, but negotiated contracts define what services will be reimbursed and at what levels, and there are modest incentives in place to encourage preventive services. Finally, the highest-risk members are placed in telephone- or home-based care-management programs to better manage their illnesses.

Another 355,000 patients were enrolled in a noncapitated HMO. HMOs are typically more restrictive than PPOs. The patient's cost to join is less, but patients usually see specialists only when they have received a referral from their primary care physician, and they go only to in-network doctors and hospitals. The financial penalty for going outside the network is more severe. And while providers are often still paid for each service they provide, more substantial incentives are available for those who deliver cost-effective quality care. In addition, providers' comparative performance is tracked.

Finally, some 290,000 patients were enrolled in an HMO plan that also included global capitation. In other words, participating primary-care physicians were paid a contracted rate (adjusted for age, gender, illness, and regional differences) for each member regardless of the number or nature of services provided. In the capitated model, it is the provider, not the payer, who takes on the risk of the cost of care. Should that cost exceed the contracted rate, the provider could actually lose money

on a given patient. By the same token, to the degree that providers can successfully manage that risk and achieve their quality targets at less cost, they also benefit from what can be a substantial financial upside. This provides a strong incentive to invest in active disease management and to work closely with patients to help them navigate the health care system. Indeed, detailed financial models suggest that primary care providers who know how to manage global capitation have the potential to earn more income than their fee-for-service counterparts for the equivalent population of patients[6]—a phenomenon that we have witnessed in our client work.

Because the demographic composition of our four samples was not identical, we used regressions to risk-adjust our data for two key factors that shape an individual's health status: age and the number of comorbidities. In other words, we compared the age composition and presence of comorbidities in each sample with the total sample average, and then adjusted each sample's mortality and other results accordingly.

To further check the validity of our findings, we took another step. We created a sample of approximately 170,000 patients in each of the four health-care plans who matched one another in terms of age, gender, minority status, number of comorbidities, and disease type. This matching exercise confirmed the findings of our larger sample with minimal variations. In addition to presenting the findings from our full sample, we report on some of the findings from this matched sample in our discussion below.

In the capitated model, it is the provider, not the payer, who takes on the risk of the cost of care.

We acknowledge a number of limitations in our data set—in particular, the fact that although we have tried to limit the impact of selection bias on our findings, we have not eliminated it entirely. The magnitude of selection bias in Medicare Advantage is a widely debated topic.[7] Additional research is necessary to prove causation, but there are three reasons why we believe that our findings are primarily the product of actual differences in care delivery. First, our Medicare Advantage samples are older, on average, with more comorbidities than our fee-for-service sample. Second, the national Medicare Advantage population consists of more minorities and lower-income and less well-educated people (all factors that correlate with medical risk) than the national Medicare fee-for-service population. Third, the risk-adjustment methodology used to set Medicare Advantage rates has removed the financial incentive for plans to select for a healthier population. (For more information, see the appendix, "Research Methodology and Limitations.")

The Impact of Alternative Models on Health Care Quality

To measure health care quality across our four delivery models, we focused on three categories of health outcomes defined by Michael E. Porter and utilized by the International Consortium for Health Outcomes Measurement (ICHOM).[8]

- *Health Status.* The first category is the overall health status of the patient. Here the chief metric was single-year mortality—whether a patient lived or died during the year under study.

- *Recovery from Acute Incidents of Care.* The second category addresses outcomes associated with acute episodes of care requiring hospitalization. Because we had access only to administrative claims data and not actual clinical-chart data, we

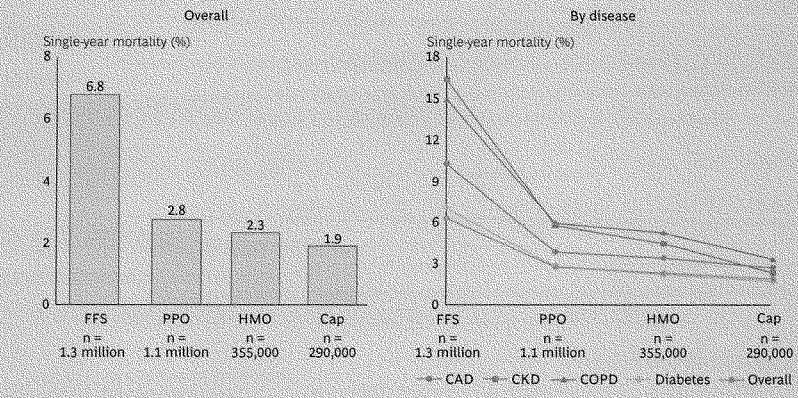
had to rely on process metrics as a proxy for genuine health outcomes: hospital admission rates, the average length of stay, and the percentage of admissions that were readmissions within 30 days of a previous discharge. At first glance, a measure such as how long a patient stays in the hospital may not appear to be an indication of health care quality. (After all, shorter stays may be the result of rules that prematurely force patients out of the hospital.) However, when length of stay is combined with 30-day readmission rates, the two metrics provide a sense of how well a care delivery model is managing acute episodes of care.

- *The Sustainability of Health over Time.* The third dimension addresses outcomes associated with the long-term management of care, especially in chronic diseases. Here we relied on a mix of genuine outcome metrics such as the degree to which the plans minimize disease-specific complications (for example, foot amputations among diabetics) and proxy metrics such as the use of specific clinical practices that represent the highest standard of care.

In addition to tracking these metrics for our sample as a whole, we did so for four major chronic diseases—coronary artery disease, chronic obstructive pulmonary disease, chronic kidney disease, and diabetes.

Single-Year Mortality. Perhaps the most dramatic finding of our research is that as we move across the spectrum from the traditional fee-for-service sample to the progressively more managed delivery models, the single-year mortality rate decreases from 6.8 percent to 1.9 percent. (See Exhibit 1.) Most of that difference

EXHIBIT 1 | Medicare Advantage Plans Reduced Single-Year Mortality



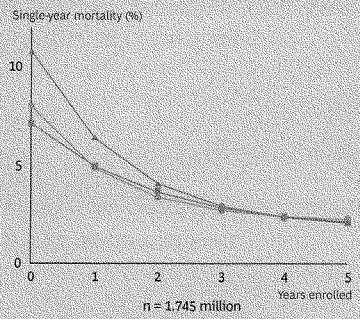
Sources: Centers for Medicare & Medicaid Services; unidentified private payer; U.S. Renal Data System 2011 Annual Data Report; Centers for Disease Control and Prevention, Diabetes Fact Sheet; BCG analysis.
Note: Although we cannot determine statistical significance because of the regression analysis used, the same comparison using matched samples was significant to at least the 0.05 level. FFS stands for fee for service; PPO, preferred provider organization; HMO, health maintenance organization; Cap, capitated health network; CAD, coronary artery disease; CKD, chronic kidney disease; and COPD, chronic obstructive pulmonary disease.

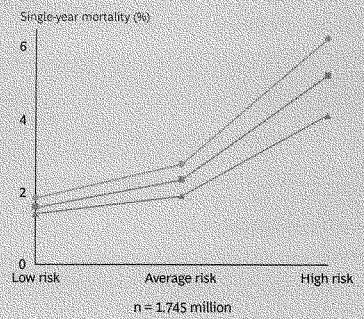
occurs between the fee-for-service and PPO samples, with smaller but consistent declines in the HMO and capitated samples. These differences in the single-year mortality rate are consistent across the four diseases we studied, with the improvements for chronic kidney disease especially dramatic.

There are also indications that patients in the three more-managed models achieve these lower levels of single-year mortality quickly—within the first year of enrollment. We compared mortality rates across the three alternative-delivery models on the basis of how many years an individual patient had been a member of one of the three types of plans. The single-year mortality rate fell sharply for patients who had completed their first year in a managed plan and then declined steadily in subsequent years. (See Exhibit 2.) The overall slope of improvement is greatest in the capitated model, which shows the lowest mortality rates for patients who had been in the plan for four years or more. These findings are particularly meaningful given that the members of the various plans had an average length of enrollment of between about two and a half and four and a half years depending on the model—which suggests that the plans are actually able to see the financial benefits of investments in more managed care delivery during a member's enrollment period.

Finally, the differences in single-year mortality in the Medicare Advantage samples were also greater for older and higher-risk patients as we move across the spectrum

EXHIBIT 2 | Mortality Was Reduced Quickly, with the Biggest Differences for Higher-Risk Patients





Average tenure in plan
PPO 2.7 years
HMO 4.1 years
Capitated 4.7 years

Sources: Centers for Medicare & Medicaid Services; unidentified private payer; BCG analysis.
Note: Because the left-hand chart does not include mortality data for those patients who were in one of the three plans for more than five years and because the regression analysis includes an additional independent variable (years enrolled), the single-year mortality results are not comparable to those in Exhibit 1. In the right-hand chart, *low-risk patients* are defined as those aged 66 years with one comorbidity, *average-risk patients* as those aged 71 years with five comorbidities, and *high-risk patients* as those aged 78 years with eight comorbidities. Although we cannot determine statistical significance because of the regression analysis used, the same comparison using matched samples was significant to at least the 0.05 level.

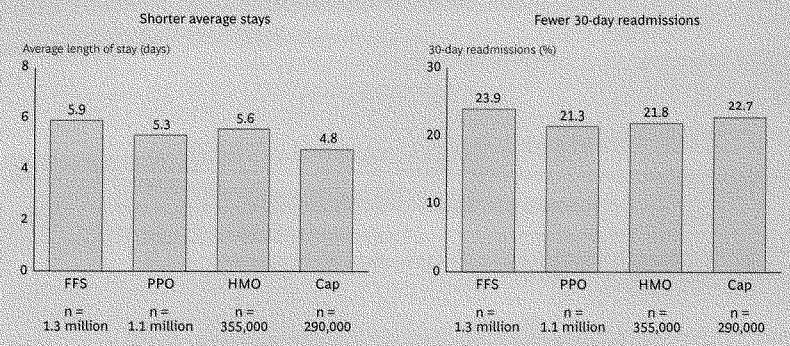
toward more managed delivery models. We compared the mortality results for three subgroups within our sample: "low risk" patients (defined as those aged 66 years with one comorbidity), "average risk" patients (those aged 71 years with five comorbidities), and "high risk" patients (those aged 78 years with eight comorbidities). For the low-risk group, the difference in single-year mortality between the PPO and the capitated samples was only 0.4 percentage points (1.8 percent versus 1.4 percent). For the high-risk group, by contrast, the difference was 2.1 percentage points (6.2 percent versus 4.1 percent). Similar results can be seen across the four diseases we studied.

Hospital Utilization Rates. Previous research has shown that more managed care-delivery models correlate with lower hospital-utilization rates.[9] Our data confirm this general trend.

There is a relatively negligible difference of about 4 percent in the share of patients admitted to hospitals across the four models. But there is a substantial reduction in the length of time that patients in the capitated Medicare Advantage plan spend in the hospital—about a 19 percent lower average length of stay compared with the fee-for-service sample. (See Exhibit 3.) This finding is at the low end of the research showing that Medicare Advantage plans have utilization rates 20 to 30 percent lower than Medicare fee-for-service. What's more, the more managed plans also have a somewhat lower percentage of readmissions, which suggests that the shorter hospital stays represent genuine improvements in the management of acute episodes of care.

That said, there does appear to be some tradeoff between length of stay and readmissions. For example, the small average length of stay of the capitated sample (4.8 days) seems to come at the price of a higher level of readmissions. But even

EXHIBIT 3 | Medicare Advantage Patients Had Shorter Hospital Stays and Fewer Readmissions



Sources: Centers for Medicare & Medicaid Services; unidentified private payer; BCG analysis.
Note: Although we cannot determine statistical significance because of the regression analysis used, the same comparison using matched samples was significant to at least the 0.05 level.

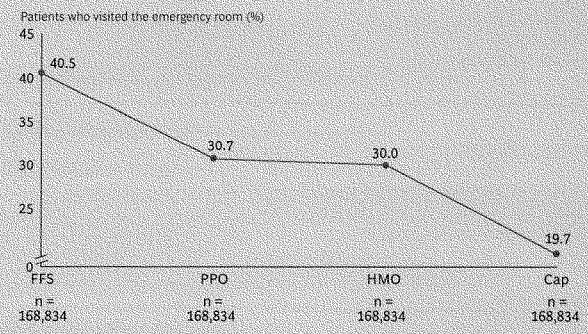
this elevated readmission rate, compared with the other alternative plans, is lower than the level for the fee-for-service sample.

Sustaining Health over Time. One of the advantages claimed by proponents of more managed delivery models is that they make it easier for providers to engage in active care management and to practice preventive medicine—thus avoiding acute episodes and invasive procedures that are both more costly and more disruptive to the patient. The data produced by our sample-matching technique described on page 6 suggest that this advantage does, in fact, exist.

Take the example of emergency room visits. About 4 in 10 of the patients in our fee-for-service matched sample visited the emergency room at least once in 2011. But for our three progressively more managed delivery models, the figure drops—to about 3 in 10 for the PPO and HMO samples and to below 2 in 10 for the capitated sample. (See Exhibit 4.) This decline in emergency room visits could reflect better management between acute episodes, better follow-up and scheduling of specialist visits, or better adherence on the part of patients to their treatment regimens.

When we looked more closely at the disease-specific data, we found that patients in the more managed plans were indeed more likely to receive recommended preventive care. The Healthcare Effectiveness Data and Information Set (HEDIS), established by the nonprofit National Committee for Quality Assurance, tracks 75 measures across eight domains of care that are broadly accepted as reflective of high-quality health care.[10] Medicare Advantage plans are rated on the basis of their adherence to the HEDIS standards, and Medicare has recently begun paying a bonus to the plans that rank the highest.

EXHIBIT 4 | Medicare Advantage Patients Had Fewer Emergency-Room Visits



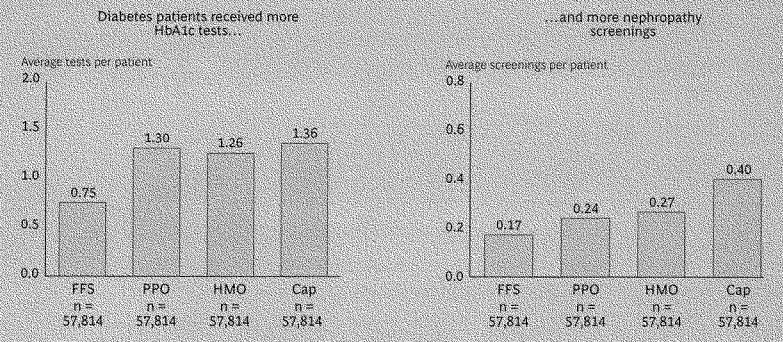
Sources: Centers for Medicare & Medicaid Services; unidentified private payer; BCG analysis.
Note: Data from matched sample of 168,834 patients in each of the four delivery models; data show percentage of patients in each sample who visited the emergency room at least once. Results are statistically significant to at least the 0.05 level for all data points.

Two key HEDIS standards for patients suffering from diabetes are frequent (at a minimum, once a year) testing for glycated hemoglobin (HbA1c), high levels of which have been correlated with cardiovascular disease and other conditions, and regular nephropathy screenings to monitor kidney function. Our matched-sample data show that the average number of HbA1c tests per patient increases from 0.75 in the fee-for-service matched sample to 1.36 in the capitated matched sample. And the average number of nephropathy screenings per patient more than doubles, from 0.17 to 0.40. (See Exhibit 5.)

As one might expect, there were also many fewer disease-specific complications in the diabetes patients in the more managed plans. Whereas the fee-for-service matched diabetic sample had an average of 11.5 amputations per 1,000 patients, the capitated matched diabetic sample had only 0.3. And whereas the fee-for-service sample had an average of 212.3 foot-ulcer procedures per 1,000 patients, the capitated sample had only 25.4. (See Exhibit 6.)

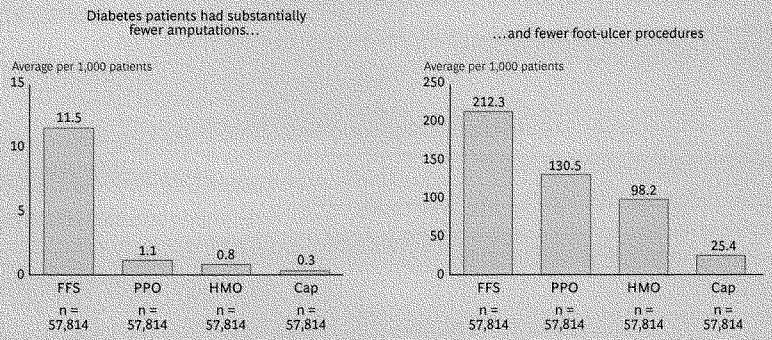
In coronary artery disease, we found that patients in the capitated matched sample underwent half as many open-heart surgeries (which are not only expensive but also highly disruptive for the patient) as patients in the fee-for-service matched sample. (See Exhibit 7.) And when invasive interventions were necessary, the tendency was to choose the less invasive option of percutaneous coronary intervention (PCI)—such as coronary stents, angioplasty, and atherectomy—as shown by the relatively high ratio of PCI to open-heart surgery in the more managed plans. Given that the single-year mortality of the patients with coronary artery disease in our sample was lower for those in the more managed plans, as shown in Exhibit 1, this pattern of clinical practice would seem to suggest that the more managed plans were simultaneously reducing costs and improving health care quality.

EXHIBIT 5 | Medicare Advantage Patients Were More Likely to Receive Preventive Care



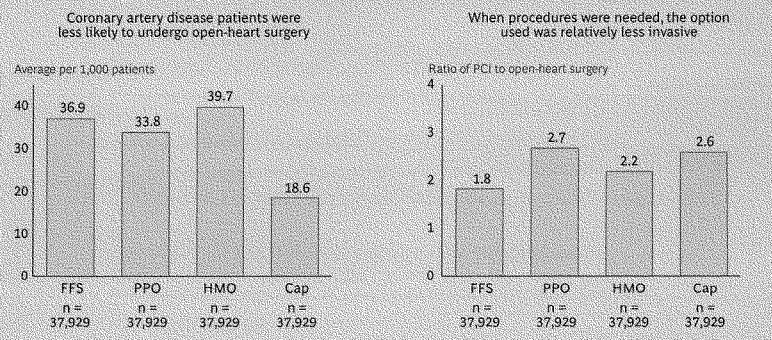
Sources: Centers for Medicare & Medicaid Services; unidentified private payer; BCG analysis.
Note: Data from matched sample of 57,814 diabetes patients in each of the four delivery models. Results are statistically significant to at least the 0.05 level for all data points.

EXHIBIT 6 | Medicare Advantage Patients Had Fewer Disease-Specific Complications



Sources: Centers for Medicare & Medicaid Services; unidentified private payer; *BMC Health Services Research*; The National Quality Forum; BCG analysis.
Note: Data from matched sample of 57,814 diabetes patients in each of the four delivery models. Results are statistically significant to at least the 0.05 level for all data points, except for PPO compared with HMO for amputations.

EXHIBIT 7 | Patients in the Capitated Sample Underwent Fewer Invasive Procedures



Sources: Centers for Medicare & Medicaid Services; unidentified private payer; AdvanceWeb; The Society for Cardiovascular Angiography and Interventions; BCG analysis.
Note: Data from matched sample of 37,929 coronary-artery-disease patients in each of the four delivery models. PCI stands for percutaneous coronary intervention. Results are statistically significant to at least the 0.05 level for all data points, except for PPO compared with HMO for PCI.

The accumulation of results suggests that one reason for the improved outcomes of the private insurance plans is their ability to more effectively and systematically manage both chronic and acute illness. Although our findings are suggestive rather than definitive, their strong directionality indicates that the more managed care-delivery models improve health care value compared with the traditional fee-for-service model. What's more, this conclusion is confirmed by a growing body of research suggesting that the introduction of organizational mechanisms like those

characterizing the Medicare Advantage plans we studied has the effect of simultaneously lowering costs and improving outcomes.[11]

Implications for Health Care Decision Makers

Our research suggests that successful U.S. Medicare Advantage plans offer a powerful model for improving health care quality. These plans have found a way to engage the right set of clinicians around the objective of delivering improved health-care value. They have also effectively realigned financial incentives to help realize improved outcomes.

This conclusion has important implications for the debate about the future of health care. First, the claim—still heard frequently in debates about health care costs—that more managed care-delivery models achieve cost savings only by eroding the quality of care appears untrue. The more managed plans that we studied delivered better care than traditional fee-for-service medicine.

Second, our findings also put into question the commonly held notion that allowing patients to have an unrestrained choice of providers will lead to quality outcomes. Even as the fee-for-service model is coming under growing criticism in the U.S., many publicly financed health-care systems (for example, in certain regions of Sweden) are encouraging private providers to offer care covered by fee-for-service reimbursement as a means to expand consumer choice and bring market forces into play. But unless such delivery models utilize the organizational mechanisms we describe, they are unlikely to contribute to improved value. In fact, they may end up reducing value.[12]

Third, the critical issue is whether a given delivery or reimbursement model has put in place the right organizational mechanisms and incentives to effectively change provider behavior, to increase innovation and experimentation, and to encourage those clinical practices that deliver cost-effective quality care.

We believe that the alternative delivery and reimbursement models represented by Medicare Advantage plans have the potential for broad applicability.

Given their track record, we believe that U.S. private insurers have a major role to play in the ongoing national efforts to improve health care value. They have accumulated considerable experience toward achieving this goal, and all stakeholders should learn about and take advantage of their efforts. Typically, private health insurers in the U.S. are seen as "middlemen" who help manage the system's risk but with little direct impact on the actual quality of care. Our research suggests otherwise: that private insurers have created an operating model that can deliver better care at a lower cost. In this respect, they represent important catalysts of innovation in clinical practice. Their role as a third party, along with their correspondingly greater scale, broad access to data, and lack of fixed infrastructure (and the corresponding fixed costs that such an infrastructure represents), put them in a position to bring about changes in clinical practice in partnership with the clinical community.

But we also believe that the alternative delivery and reimbursement models represented by these Medicare Advantage plans have the potential for broad applicability, whatever the mix of private and public health insurance in a nation's health care system. Health care systems around the world can adopt components of

what has made these alternative care-delivery models successful. In order to do so, however, payers, providers, and policymakers must know precisely what it takes to implement these organizational mechanisms effectively and how to replicate them across different types of health care systems. We will explore these issues further in subsequent research.

NOTES

1. See Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Boston: Harvard Business School Press, 2006); and *Improving Health Care Value: The Case for Disease Registries,* BCG Focus, December 2011.

2. Bruce E. Landon, Alan M. Zaslavsky, Robert C. Saunders, L. Gregory Pawlson, Joseph P. Newhouse, and John Z. Ayanian, "Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003–09," *Health Affairs* 31 (December 2012): 2609–2617.

3. Roseanna Sommers, Susan Dorr Goold, Elizabeth A. McGlynn, Steven D. Pearson, and Marion Danis, "Focus Groups Highlight That Many Patients Object to Clinicians' Focusing on Costs," *Health Affairs* 32 (February 2013): 338–346.

4. See "Health Reform Should Focus on Outcomes, Not Costs," BCG article, October 2012.

5. See, for example, Mark Smith, Robert Saunders, Leigh Stuckhardt, and J. Michael McGinnis, eds., *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (Washington: National Academies Press, 2012).

6. See Allan H. Goroll, Robert A. Berenson, Stephen C. Schoenbaum, and Laurence B. Gardner, "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," *Journal of General Internal Medicine* 22 (March 2007): 410–415.

7. See Lauren Nicholas, "Better Quality of Care or Healthier Patients? Hospital Utilization by Medicare Advantage and Fee-for-Service Enrollees," *Forum for Health Economics & Policy* (forthcoming).

8. Michael E. Porter, "What Is Value in Health Care?" *New England Journal of Medicine* 363; 26 (December 2010): 2477–2481; and International Consortium for Health Outcomes Measurement (ICHOM), "Measurement in Value-Based Health Care," available at http://ichom.org/measures/measurement-in-value-based-health-care/.

9. See "Using State Hospital Discharge Data to Compare Readmission Rates in Medicare Advantage and Medicare's Traditional Fee-for-Service Program," AHIP Center for Policy and Research Working Paper, May 2010; and Landon et al., "Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003–09."

10. See National Committee for Quality Assurance, "HEDIS and Quality Compass," available at http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx.

11. For examples of this research, see Zirui Song, Dana Gelb Safran, Bruce E. Landon, Mary Beth Landrum, Yulei He, Robert E. Mechanic, Matthew P. Day, and Michael E. Chernew, "The 'Alternative Quality Contract,' Based on a Global Budget, Lowered Medical Spending and Improved Quality," *Health Affairs* 31 (August 2012): 1885–1894; Stephanie Stock, Anna Drabik, Guido Büscher, Christian Graf, Walter Ullrich, Andreas Gerber, Karl W. Lauterbach, and Markus Lüngen, "German Diabetes Management Programs Improve Quality of Care and Curb Costs," *Health Affairs* 29 (December 2010): 2197–2205; and Stefan A. Baeten, N. Job A. van Exel, Maaike Dirks, Marc A. Koopmanschap, Diederik W.J. Dippel, and Louis W. Niessen, "Lifetime Health Effects and Medical Costs of Integrated Stroke Services—A Non-Randomized Controlled Cluster-Trial Based Life Table Approach," *Cost Effectiveness and Resource Allocation,* 2010, 8:21.

12. See Marty Makary, *Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care* (New York: Bloomsbury Press, 2012).

APPENDIX: RESEARCH METHODOLOGY AND LIMITATIONS

To arrive at our four samples, we started with claims data and demographic information from 2011 for some 4.3 million Medicare beneficiaries. About 2.6 million of these patients were a representative sample of the traditional fee-for-service model. These data were purchased from the federal government's Centers for Medicare & Medicaid Services (CMS). The remaining 1.7 million patients in our initial set were enrolled in one of three types of private Medicare Advantage plans. These data were provided by a leading private insurer and have been audited by the U.S. government.

Next we filtered the fee-for-service patient data to make them comparable to the data for the Medicare Advantage patients. Some 860,000 fee-for-service patients were excluded owing to missing demographic or claims information. We excluded another 400,000 patients to ensure that we looked at fee-for-service patients only in states where the private insurer had a meaningful presence. This left us with a fee-for-service data set of about 1.3 million patients out of about 3 million overall.

Although our data set is extremely broad and comprehensive, there are a number of limitations in the data that influence the conclusions that can be drawn.

Our data represent a snapshot in time: health outcomes for the single year of 2011. We do not have longitudinal data that would let us know whether our findings are consistent over time. What's more, because our study focuses exclusively on Medicare patients, our findings are limited to a sample of older and relatively sicker patients and may not apply to a younger or less sick population. This older population generates the lion's share of health care costs and will generate even more as the baby boomers reach Medicare eligibility. Although people eligible for Medicare represent only 12 percent of the U.S. population, they are responsible for 34 percent of overall U.S. health-care spending.

The data in our three Medicare Advantage samples come from a single private insurer. Therefore, the better outcomes in these samples may reflect the strong performance of this particular insurer, rather than that of more managed delivery systems in general. Nevertheless, the results of even a single payer demonstrate the potential of a more managed care-delivery model.

Our database did not contain any cost data. So while we can compare the nature of health outcomes across our four models, we cannot determine what those specific outcomes cost. However, there is a growing literature demonstrating that health care costs drop with the use of the organizational mechanisms deployed by the plan types we studied, and it is reasonable to assume that that relationship also applies here.

We had access to demographic and claims data only at the individual state level. Therefore, we could not account for any sample differences at the county level or for varying rates of readmission across individual hospitals. And because the CMS data cap the number of diagnoses at 12, we were able to collect only a limited number of diagnoses for each patient. The lack of CPT II codes in our data also meant that we were unable to capture any detail about the specific severity of comorbidities.

Our regression analysis may also be distorted by differences between Medicare fee-for-service and Medicare Advantage plans in the documentation of patient comorbidities. Medicare Advantage payers have a strong financial incentive to capture the complete range of comorbidities for a given patient; as a result, they put in place analytics and programs to assist providers in documenting these comorbidities more accurately, and their patients tend to have a higher number of comorbidities on average.[1] All three of the Medicare Advantage samples that we studied, for instance, had older patients and more comorbidities than our fee-for-service sample. If the fee-for-service sample in fact had more comorbidities than were documented in our data, then our regressions may have overestimated the degree of difference in outcomes from the Medicare Advantage plans.

Another limitation of our regression analysis is that it makes it impossible to meaningfully calculate statistical significance. However, when we replicated our analyses in our matched sample, we found that all the results (with two minor exceptions) were statistically significant to at least the 0.05 level and often to the 0.001 level.[2]

Perhaps most important, our data do not account for all possible selection bias among the four models studied. Despite having controlled for age and number of comorbidities, we cannot determine other indicators of health status. Our data sample does not include socioeconomic or educational status or, for instance, whether patients are smokers—all factors that influence health status. However, while the nationwide Medicare fee-for-service population is slightly older than the Medicare Advantage population, the latter has a larger proportion of minorities and lower-income and less well educated people.[3] These demographic measures would suggest that Medicare Advantage plans serve a sicker population (perhaps because such patients are attracted to the plans' increased benefits), which makes the better outcomes we found in the Medicare Advantage plans we studied even more impressive.

One final limitation concerns the 1.1 million patients in our PPO sample. Roughly a quarter of these patients were in fact in a private fee-for-service plan, but we were unable to identify these patients from the data available. If our hypothesis about the benefits of more managed care delivery is correct, the inclusion of these patients would negatively impact the outcomes and performance of this PPO group. Had we been able to exclude these patients, the outcomes for the PPO sample might therefore have been even better than what we have reported.

NOTES

1. See Centers for Medicare & Medicaid Services, "Medicare Advantage Rates & Statistics," available at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data-Items/2013Rates.html.

2. The two exceptions were the number of diabetic foot amputations between the PPO and HMO matched samples in Exhibit 6, and the number of percutaneous coronary interventions between the PPO and HMO matched samples in the left-hand chart of Exhibit 7.

3. See Kaiser Family Foundation, *Medicare Chartbook, Fourth Edition,* 2010; AHIP Center for Policy and Research, *Low-Income & Minority Beneficiaries in Medicare Advantage Plans, 2010,* May 2012, and *Low-Income & Rural Beneficiaries with Medigap Coverage, 2010,* May 2012; and Centers for Medicare & Medicaid Services, *CMS Special Needs Plan Comprehensive Report,* December 2010.

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For Further Contact

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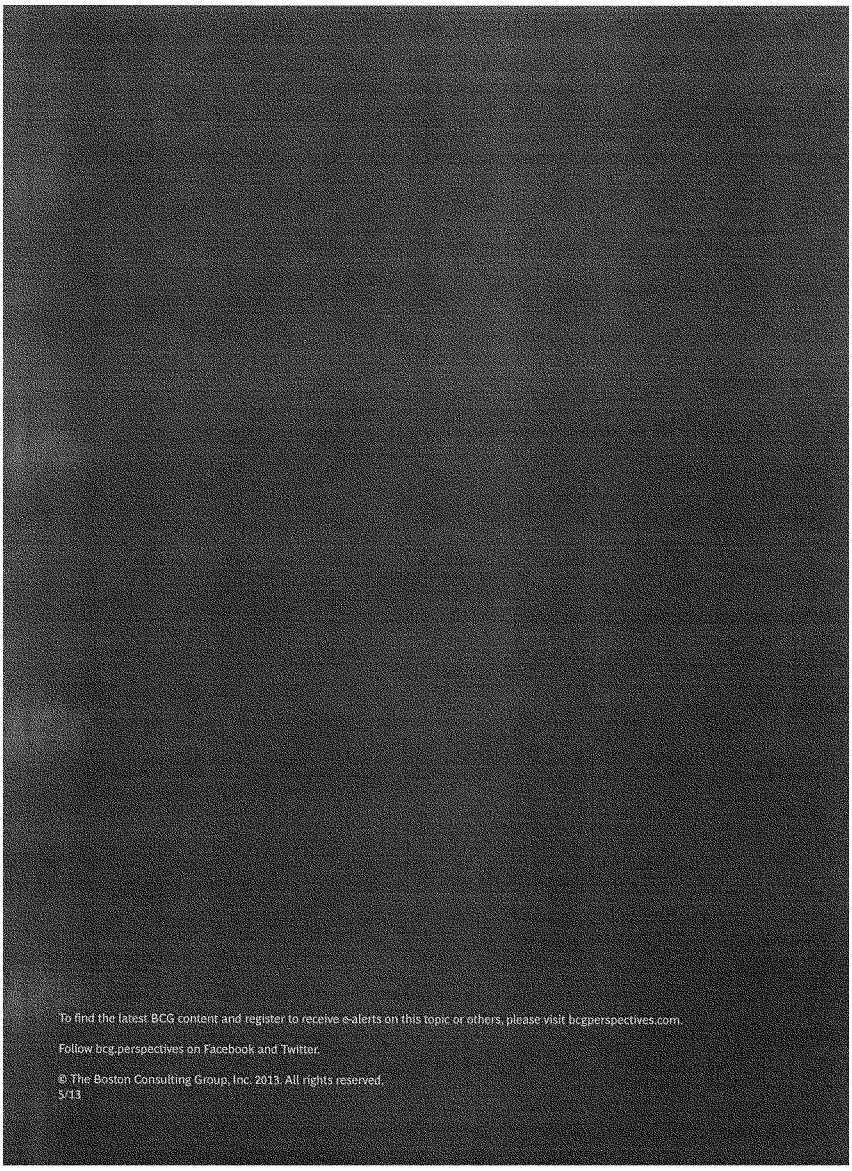
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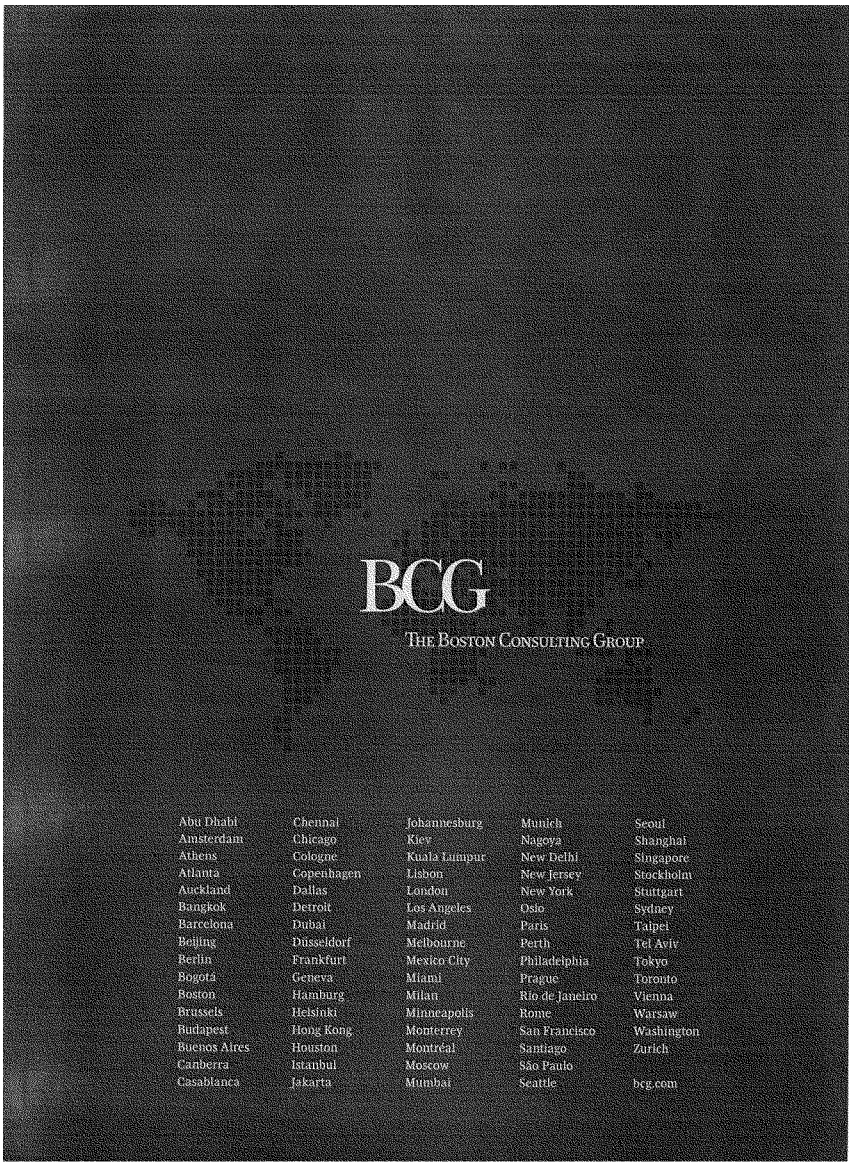
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Mr. PITTS. The Chair thanks the gentleman. That concludes the summaries.

Before we go to questioning, I'd like to seek unanimous consent to submit for the record a letter from the 60 Plus organization. Without objection, so ordered.

[The information follows:]

The 60 Plus Association

515 King Street • Suite 315 • Alexandria, VA 22314
Phone 703.807.2070 • Fax 703.807.2073 • www.60Plus.org

Kill the Death Tax. Protect Social Security and Medicare. Energy Security.

December 3, 2013

Re: United States House of Representatives Energy and Commerce Committee's Subcommittee on Health Hearing on "Medicare Advantage: What Beneficiaries Should Expect Under the President's Health Care Plan"

Dear Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee:

As Chairman of the 60 Plus Association, representing over 7 million senior citizen activists nationwide, I commend you for investigating the impact that cuts to the Medicare Advantage program will have on the health and well-being of America's seniors.

Since the creation of the Medicare Advantage program in 2003 through the Medicare Modernization Act, senior citizens have had the option of participating in private plans that meet their personal medical needs, and studies have shown that Medicare Advantage performs better than traditional Medicare in many metrics ("How Competition Improves Quality: The Case of Medicare Advantage" by Center for Policy Innovation.)

Why do so many America's seniors prefer Medicare Advantage? These MA plans limit yearly out-of-pocket expenses compared to the enormous financial burden an extended hospital stay could incur under original Medicare. In addition to paying the Medicare Part B premiums, additional enrollment and cost-sharing co-pays may (but not always) apply, based upon the plan selected, and plans may offer expanded benefits, including skilled nursing, vision, hearing, dental care and health and wellness programs.

41 MILLION senior citizens 65 and over currently participate in Medicare. 14 MILLION of these seniors opted to enroll in the Medicare Advantage program, a private alternative to traditional Medicare, often through a Health Maintenance Organization (65% in 2011) or a Preferred Provider Organization (Local PPOs were 18% and Regional PPOs were 9% in 2011). 41% of these Medicare Advantage enrollees have incomes of $20,000 or less, and 1 in 5 are minorities.

Of the $556 BILLION total Medicare benefit payments made in 2012, only 22% was for Medicare Advantage care (statistics according to the Kaiser Family Foundation.)

In spite of the overwhelming popularity of Medicare Advantage, some plans have already been cancelled. I speak from experience. Shortly after Obamacare (Patient Protection and Affordable Care Act) was shoved down American's throats in 2009 despite overwhelming opposition, and despite repeated assurances by President Barack Obama that "If you like the insurance you now have, you can keep it...period", I received a letter that my Medicare Advantage coverage was being terminated, and I would have to seek insurance under traditional Medicare. I liked my Medicare Advantage plan and felt it well met my health care requirements. I couldn't keep it...period.

As Chairman of 60 Plus, I spent months on the road last year, journeying across the nation to meet with taxpayers, families, small business owners and various civic and policy organizations. As we visited almost every state we held town halls and rallies, listening to the concerns of seniors and soon-to-be seniors. Here's what they told us:

- Seniors overwhelmingly dislike Obamacare, and are very confused about what these changes will mean to the quality of their health care
- They fear that access to medical professionals and facilities will be severely limited, causing critical delays in care
- Unaccountable bureaucrats will take medical decisions away from providers working together with patients and their families to determine the best course of treatment.
- They were deeply concerned by evidence of back-room dealing between the Obama Administration and AARP (who makes $672 MILLION selling Medigap insurance policies to seniors, and stand to increase their fortunes under Obamacare) that was exposed by the 2012 House Energy and Commerce Committee investigation It showed an extraordinary amount of coordination between the supposedly pro-seniors group and White House officials to help pass Obamacare, despite evidence at the time that AARP's membership overwhelmingly opposed passage – by a margin of 14 to 1.

The Energy and Commerce Committee released this in a memorandum dated June 8, 2012:

> AARP was overwhelmed with calls opposing the health care legislation: "Our calls against reform are coming in 14 to 1." Phone calls were not the only thing letting AARP know that embracing the White House push for any health care law might not be publicly supported. When the White House Office of Public Engagement approached AARP to provide an official for a roundtable, a representative replied: "I think we will try to keep a little space between us and the White House on the issue. Our polling shows we are more influential when we are seen as independent, so we want to reinforce that positioning."* Ten days later an AARP representative forwarded Messina and DeParle a press release announcing "Survey Finds AARP Members Back Critical Provisions of Health Care Reform Legislation." Messina replied: "Excellent." The AARP endorsed both the House health care bill and the Senate health care bill.
>
> *From the email from John Rother of AARP to the White House's Ann Widger on November 6, 2009 12:01 pm

While the Medicare Advantage patch that went into effect on April 19, 2011 BY PRESIDENT OBAMA'S ADMINISTRATIVE ACTION PRIOR TO THE 2012 ELECTIONS temporarily delayed some cuts in benefits, over $300 BILLION of the more than $715 BILLION cuts to Medicare under Obamacare will come from the Medicare Advantage program. At that time, Senator Orrin Hatch of Utah (Ranking Republican of the Senate Finance Committee) and Representative Dave Camp of Michigan (Chairman of the House Ways and Means Committee) called this patch "a thinly veiled use of taxpayer dollars for political purposes."

What will be the future impact on Medicare Advantage programs? Those Medicare Advantage programs that survive Obamacare are expected to see cuts in coverage and reduced options for care. Health care experts Robert Book and James Capretta have written: "Every patient who would have enrolled in an MA plan under prior law will experience a loss in the value of his or her Medicare coverage." (Reductions in Medicare Advantage Payments: The Impact on Seniors by Region).

Indeed, this is another example that "Medicare as we know it" no longer exists, and America's seniors, unfortunately, are being "thrown off the cliff."

Sincerely,

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The 60 Plus Association is a 20-year-old nonpartisan organization working for death tax repeal, saving Social Security and Medicare, affordable prescription drugs, lowering energy costs and other issues featuring a limited government, less taxes approach as well as a strict adherence to the Constitution. 60 Plus calls on support from over 7 million citizen activists. 60 Plus publishes a newsletter, SENIOR VOICE, and a Scorecard, bestowing awards on lawmakers of both parties who vote "pro-senior." 60 Plus has been called "an increasingly influential senior citizen's group" and the acknowledged conservative alternative to the liberal AARP.

Mr. PITTS. I will now begin the questioning and recognize myself for 5 minutes for that purpose.

Mr. Holtz-Eakin, since passage of the President's healthcare plan, millions of Americans and their families have received insurance cancellation notices. Do you think Medicare Advantage may be Obamacare's next victim, and if so, what might beneficiaries in Pennsylvania expect over the coming years in terms of plan choices, cost, foregone benefit offerings and provider networks?

Mr. HOLTZ-EAKIN. Thank you, Mr. Chairman. Indeed, I am concerned about the future of Medicare Advantage, as I said in my opening statement. The work we have done on the implications of ACA cuts, for example, in Pennsylvania, would suggest that in 2014, there would be an average loss of benefits per beneficiary of about $2,200, that this is about a 19 percent reduction in those benefits, and that we would see a decline in the activity of Medicare Advantage to about 113,000 Pennsylvanians, and those numbers for 2014 are of concern but I am more troubled by the trajectory over the succeeding 5 years and the full cuts under the Affordable Care Act as to whether Medicare Advantage will remain a viable option within the Medicare program and deliver the comprehensive benefits.

And I just want to echo the statements that we heard in many of the opening remarks. The Medicare population is so different than when Medicare was originated. It is now a population that has multiple chronic conditions and comorbidities. It requires a coordinated approach to care. That is the route to both better health and financial future for Medicare as a whole. Medicare Advantage, I think, is an important steppingstone to that future.

Mr. PITTS. Thank you.

Dr. Margolis, as you know, this committee has been committed in a bipartisan form to address access concerns in part by improving the flawed physician patient formula for participating Medicare doctors. However, I believe Medicare Advantage plays a key role in ensuring the physician-patient relationship for seniors and the disabled. What impact, in your opinion, will the permanent solution to the flawed SGR formula have on the viability of the Medicare Advantage program?

Mr. MARGOLIS. Thank you, Mr. Pitts. There is no question that the cuts that are proposed are coming down on Medicare Advantage, and I would specifically stress the rescaling of the risk adjustment factor, which really was a key component in what I believe is making it a positive incentive to care for the sick and fragile patient was to be paid based on the acuity of the patient, and so the potential of reducing significantly the payments relative to the most expensive patients starts to flip back to that possibility that the people will not be able to gain care if they are really sick, and that is a potential serious problem.

And I would also like to just say that Medicare Advantage should not, in our opinion, be the pay-for for an SGR fix. I think that as you have heard from all these other witnesses that it is extremely important for the seniors of our country, 10,000 more of which are entering Medicare every day, to be able to access good coordinated care and especially for that 5 percent of patients that are eating up 52 percent of all healthcare dollars, those sickest and most frag-

ile patients, to be able to access the doctors of their choice and get the care they need.

Mr. PITTS. Thank you. Here is a question for the panel. Medicare Advantage has a proven record of success and is popular with seniors because it provides better services, a higher quality of care and increased care coordination. To ensure the program's viability, I believe there are several existing reform proposals for Medicare Advantage that merit further discussion and feedback, concepts like overlaying a value-based insurance design over the existing Medicare Advantage program to address a substantial variation in value across healthcare services and providers, bipartisan policies such as those introduced by Representative Keith Rothfus of Pennsylvania that would restore choices for Medicare Advantage beneficiaries and not limit their options to traditional FFS or their existing plans, improvement to the program's special needs plans and improvements to the program's risk adjustment framework that would improve accuracy of payments and account for chronic conditions.

What, if any, short-term reforms could we consider that would ensure the viability of the program in promoting maximum value and high-quality coordinated care for Medicare beneficiaries? We will start with you, Mr. Kaplan.

Mr. KAPLAN. First of all, thank you, Mr. Chairman. The best way I would answer that question is, is that there are a lot of successes that are already in place in Medicare Advantage. I think everybody on the panel today has said that Medicare Advantage is a program to look at with some very positive reactions.

What I think happens fundamentally in the Medicare Advantage program is that it allows for more of a freedom of choice among the different competitors in there being the insurance companies that are offering those programs and allows for the members who choose to go into those programs to navigate themselves around to different programs, to make a choice and to find what best meets their needs. That sort of freedom of choice has allowed for the programs to prosper based on what they offer to the members who sign up for their programs as opposed to mandating things in different ways.

So the competitive model amongst the different insurance companies who are offering different programs in different States, I think that strong model has allowed for the growth of the program to be so successful and effective at practicing the medical care that we all are talking about that we want to do for the senior population.

Mr. PITTS. Thank you. My time is expired. I will give you this question and I will submit it in writing and you can respond for the record.

The Chair now recognizes the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I am going to ask my questions of Mr. Baker because you seem to be able to clear up a lot of the myths that I am hearing from the Republican side.

As you heard, opponents of the ACA say that the Medicare Advantage program will be obsolete because of cuts in the Affordable

Care Act. The Republicans basically think the Affordable Care Act is the end of the world. I mean, you understand all that.

Mr. Baker, do you feel that the Medicare Advantage program is stronger now and more secure for beneficiaries than before the Affordable Care Act? If you could just answer that?

Mr. BAKER. Sure. I think there are a couple components to that. One is that this equalization of payments between the Medicare Advantage program and the traditional or original Medicare program, I think once again there is an equity there that has been established as well as the fact that Part B premiums have come down or stabilized for everyone in the Medicare program. I think the other piece is that consumers are better protected in Medicare Advantage. Some plans had increased cost sharing for services like chemotherapy, higher cost sharing than is allowed in the traditional Medicare program. The Affordable Care Act has equalized once again cost sharing so that sicker beneficiaries aren't discriminated against—the 85 percent Medical Loss Ratio that is required in Medicare Advantage now, making sure that 85 percent of those premium dollars, both from consumers as well as from the government, are going towards medical costs, not other administrative costs. The star ratings—we now have a rating program where plans have one to five stars based upon their quality and plan performance. This has been an important tool for consumers to choose between plans and also that quality information has been getting out to consumers and I think more can be done in that regard but I think is very good.

The other thing is the out-of-pocket maximums that were introduced over the course of the last few years and have provided important protections for consumers so that these Medicare Advantage protections not only make the program more equal, if you will, between the traditional or original Medicare program but also ensure that consumers are better protected with consumer rights and consumer protections once they are in the plan.

Mr. PALLONE. So obviously you feel that Medicare Advantage is stronger now and more secure because of the ACA?

Mr. BAKER. Yes, I do, and I think consumers are better protected within the Medicare Advantage program because of the ACA.

Mr. PALLONE. Do you think that the changes pursuant to the ACA give beneficiaries more confidence in the program, might even make them more comfortable in choosing a Medicare Advantage plan?

Mr. BAKER. I think it does. I think the ACA with the star ratings program, with other quality initiatives in the Medicare Advantage plan have made consumers more confident. We find that folks are looking at these star ratings or looking at these other quality metrics that are now available under the ACA. I think they also are—many of the consumers that we talk to appreciate that they have a choice between Medicare Advantage and original Medicare. So I think it is also important that the original Medicare program, which is the base of all of this, be kept strong and be kept as a very viable option for folks that Medicare Advantage either hasn't worked for or it won't work for in the future.

Mr. PALLONE. All right. And can you tell me how robust the choices are for seniors in the MA program? How many choices do they have?

Mr. BAKER. Right. I think on average, consumers continue to have about 18 plan choices, and I think Ms. Gold went through some of those metrics in her testimony. We find for the most part, and this is both true in the Medicare Advantage program as well as in the Part D prescription drug program, that consumers are really—the biggest question we have from consumers is, they have too many choices and they are too confused by the variety of plans. So over the last few years, the Centers for Medicare and Medicaid Services has made some headway in tamping down the number of choices that aren't meaningful. By that, I mean there might be one little tweak to a plan to make it somewhat different than another plan that a company is offering and, you know, folks get confused by those tweaks that don't have a real substantive component to them. And so narrowing choices in that way has helped people actually make better choices.

Mr. PALLONE. And you don't feel that—I mean, again, you don't buy the naysayers who say that the ACA is going to narrow choices for seniors in the MA program?

Mr. BAKER. It has not at this point, not substantively. We see plenty of plan choices out there in the markets where we are seeing clients. Once again, our problem in counseling most of our consumers, really all of our consumers, isn't that they don't have a choice, it is that they have too many choices of Medicare Advantage plans before passage of the ACA and after passage of the ACA.

Mr. PALLONE. Thank you very much.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the vice chairman of the full committee, Ms. Blackburn, 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and thank you all for being here.

Dr. Margolis, I want to come to you. You talked a bit about the fragile and vulnerable populations, and I want to go back to that—end-stage renal disease. I recently found out that those Medicare Advantage enrollees that have end-stage renal disease have access to a coordination of care that is not available to others. It is not an option for those that are in standard Medicare. So why should Medicare Advantage not be an option for all Medicare enrollees?

Mr. MARGOLIS. Thank you, Mrs. Blackburn. I support that. I believe that coordination of care is ideal for sick and fragile patients especially. ESRD, I know they are pilots now at CMS to try to incorporate population health for ESRD. I would encourage them to be strengthened. I think it is an artifact of the way the law was originally written that ESRD patients were not allowed to enroll in Medicare Advantage. That could and should be changed, in my view. The way that works is that if a patient has chronic renal disease and enrolls in Medicare Advantage and becomes an end-stage patient, they can stay in Medicare Advantage, but if they have already been diagnosed as end-stage renal disease, they are not allowed to enroll in Medicare Advantage.

Mrs. BLACKBURN. It would be an element of fairness into the system that would allow——

Mr. MARGOLIS. I believe that would be an improvement, yes, ma'am.

Mrs. BLACKBURN. All right.

Mr. Kaplan, I want to come to you for a minute. I loved listening to your testimony today. I have to tell you, in my district, seniors love their Medicare Advantage. We have got a program called Silver Sneakers in our district, and people come to town hall meetings, they talk to me about Silver Sneakers and how they are doing, and I have looked at some of the work that they have done and the surveys, better outcomes for physical and emotional health, more activity. It has just been a great program.

So as I have listened to you all today, talk to me for a minute. We talk about stabilizing Medicare, giving seniors more choices, giving them more options. Should Medicare Advantage not be the platform for Medicare reforms and give seniors more choice and options, not less?

Mr. KAPLAN. Well, first of all, thank you for the nice comments.

I am a huge fan of Medicare Advantage for exactly the reasons you say. It aligns the incentives so that the providers and the payers work together to try to figure out what is the best way to take care of their members and their patients, and when they align the incentives, they start to work on things, and they say one of the most important things is to coordinate care, as Dr. Margolis talked about, which is, let us coordinate the care for especially these complex members and so forth, let us find things that can help them to prevent having the diseases either progress or even begin. All these things are aligned. All these things are the idea of aligning incentives, coordinating care, and it is all for the benefit of the member. And so therefore I do believe, as you said, that Medicare Advantage is a wonderful pilot for us as a society, because what it does is, it shows that we can find a way to curb the growth of healthcare costs, we can find a way to improve——

Mrs. BLACKBURN. So curb the cost, give greater access and provide better outcomes?

Mr. KAPLAN. Correct.

Mrs. BLACKBURN. Mr. Holtz-Eakin, do you want to weigh in?

Mr. HOLTZ-EAKIN. I would just echo the fairness issue, which I think is important, and we know that Medicare as a whole is facing a very, very problematic financial future. If we can find ways to control those costs and provide better care, we should, and this is a route to that.

Mrs. BLACKBURN. Let me ask you this. When you look at the implementation of the ACA and the cuts that are being made, who is most impacted by the MA cuts that are there? Is it seniors? Is it physicians? Is it the support system for seniors? What in your research do you see? Yes, sir?

Mr. HOLTZ-EAKIN. This is impact directly to the seniors whose choices will be restricted, whose benefits will be reduced, and I am deeply concerned about the long implications. I understand the testimony of Mr. Baker about consumer protections and confidence in the program but that is at odds with the fact that the CBO, for example, projects that there will be 5 million fewer enrollees in Medicare Advantage in 2019, if they felt more confident, we got 10,000 new seniors every day, you would expect the number to rise, not

fall, and I think that is stark testimony to the financial underpinnings being not strong enough and then that will limit the benefits and the choices of seniors.

Mrs. BLACKBURN. Yield back.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the ranking member emeritus, Mr. Dingell, 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy and for your kindness.

This is an important moment, and the American people are counting on us. I am concerned that the committee might be holding another hearing to try to scare people about the Affordable Care Act and its impact on Medicare Advantage when the facts do not support those claims. The questions I have today will focus on how ACA impacts Medicare Advantage as well as traditional Medicare. I would point out that when we adopted the idea of Medicare Advantage, we were told that they were going to give us a lot more insurance and a lot less cost to senior citizens, and I have heard constant whining ever since that we have not done that.

In any event, we have a problem here because that program is costing taxpayers significantly more than traditional Medicare while providing only similar services.

So Mr. Baker, yes or no, is it correct that in 2009 before passage of ACA, CMS paid Medicare Advantage plans $14 billion more than if the same care had been provided under traditional Medicare? Yes or no.

Mr. BAKER. Yes.

Mr. DINGELL. And this averages out to about $1,000 per beneficiary? Yes or no.

Mr. BAKER. Yes.

Mr. DINGELL. Now, additionally, Ms. Gold, a 2009 MedPAC report found that Medicare Advantage payment benchmark was 118 percent of what Medicare would spend. Is that correct?

Ms. GOLD. Yes.

Mr. DINGELL. Now, Mr. Baker and Ms. Gold, is it fair to say that the reforms made by ACA were intended to align Medicare Advantage payments with traditional Medicare payments? Yes or no.

Ms. GOLD. Yes.

Mr. BAKER. Yes.

Mr. DINGELL. Now, despite claims made by some of my colleagues, these reforms have not ruined Medicare Advantage. In fact, the program is strong and growing. Earnings are doing fine. Salaries, dividends, bonuses and all those other good things to the companies and their officers who are participating are growing.

Now, Mr. Baker, how many people are enrolled in Medicare Advantage today? I believe the number is 15 million. Is that right?

Mr. BAKER. Correct. Yes.

Mr. DINGELL. Now, Mr. Baker, is it correct that Medicare Advantage enrollment has increased 30 percent from 2010 to 2013? Yes or no.

Mr. BAKER. Yes, it is.

Mr. DINGELL. It seems like they are doing pretty well, doesn't it?

Mr. BAKER. Yes, it does.

Mr. DINGELL. Now, Mr. Baker, is it correct that the average Medicare beneficiary will have a choice between 18 plans available to them in 2014? Yes or no.

Mr. BAKER. Yes, it is.

Mr. DINGELL. So Mr. Baker and Ms. Gold, the Affordable Care Act has not resulted in a drastic decrease in the number of plans available to seniors who choose to participate in Medicare Advantage nor has it decreased the number of people participating in the program? Is that correct? Yes or no.

Ms. GOLD. Yes.

Mr. BAKER. Yes.

Mr. DINGELL. Thank you. Now, in fact, I note that ACA has provided many benefits to this population and will continue to do so. Most importantly, the ACA has improved the solvency of the entire Medicare program, something which is not properly addressed by people who are critical of ACA.

Now, Mr. Baker, is it correct that Medicare hospital insurance trust fund is now solvent through 2026? That is 10 years longer than prior to the passage of ACA. Yes or no.

Mr. BAKER. Yes.

Mr. DINGELL. That tends to show that this was quite helpful to the Medicare trust fund, right?

Mr. BAKER. Yes, it does.

Mr. DINGELL. Now, in 2012, 34.1 million Medicare beneficiaries were able to access preventive services such as mammograms and colonoscopies with limited cost sharing. Is that correct? Yes or no.

Mr. BAKER. Yes.

Mr. DINGELL. Now, some 7.9 million seniors have saved over $8.9 billion since the passage of ACA, and that is thanks to the donut hole being closed. Is that right?

Mr. BAKER. Yes.

Mr. DINGELL. And the donut hole is going to be closed completely by sometime around 2020. Is that right?

Mr. BAKER. That is correct, yes.

Mr. DINGELL. So thank you, gentlemen and ladies. This committee has a great tradition of working together to solve the pressing issues of the day. I hope we can resume this tradition with vigor and focus on the facts rather than continuing to try to scare people about the Affordable Care Act. Let us give it a chance. Let us work together. Let us see that it has a chance to provide the benefits to the society and the practice of medicine and to the sick, ill and ailing in this country that we want to have.

Mr. Chairman, I thank you for your courtesy.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the vice chair of the subcommittee, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

Dr. Holtz-Eakin, you were kind of left out of that last exchange. Do you have quick thoughts on the $14 billion excess cost for Medicare Advantage that Chairman Dingell referenced?

Mr. HOLTZ-EAKIN. The reimbursements should be aligned with quality, and I think the most important issue is the quality of care that seniors receive under Medicare Advantage as opposed to fee-for-service medicine.

Mr. BURGESS. Let me switch gears a little bit. You know, the Affordable Care Act, and I was here through the entirety of how it came through the committee and how it came through Congress, and it becoming pretty obvious today that there were some assumptions and some promises that were made in the Affordable Care Act that have now turned out to not be true, and I would submit that those weren't just errors in projections, those were actually active and purposeful deceptions. If the administration had been honest with Americans about this bill, it very likely never would have passed.

So the Affordable Care Act does take $716 billion out of the Medicare program. Is that correct?

Mr. HOLTZ-EAKIN. That is correct.

Mr. BURGESS. And the portion that is taken from Medicare Advantage is about $150 billion. Is that correct/

Mr. HOLTZ-EAKIN. Yes.

Mr. BURGESS. So that is taken away from our seniors, the Medicare Advantage plans. I mean, I can remember distinctly speeches given, particularly during the Democratic Convention in 2012, that these are merely overpayments to doctors and hospitals; this is not a real cut. It is just taking away money that shouldn't have been paid in the first place. Do you recall those speeches?

Mr. HOLTZ-EAKIN. Not specifically but I remember the claims.

Mr. BURGESS. So do you agree with the administration, with the American Association of Retired Persons, Congressional Democrats that these cuts were merely ridding the plans of inefficient payments?

Mr. HOLTZ-EAKIN. I don't agree with that. They are part of an historic strategy of provider cuts that has always backfired. The SGR is the leading example. It limits access to seniors in the end. It doesn't take out excess costs. And a continued reliance on this strategy is going to damage Medicare and not save its financial future. We need to change strategies.

Mr. BURGESS. I agree with you.

You know, there was an article in the paper recently that United Health Care was forced to limit access to some doctors because of reductions in Medicare Advantage. There was an article in USA Today that talks about a story about a patient named Dorothy Sanay that her doctor had some bad news after her last checkup but it wasn't about her diagnosis. Her Medicare Advantage plan from United was terminating her doctor's contract after February 1st, and she also found out she was losing her oncologist at the prestigious Yale Medical Group. She is 71 years old and on Medicare.

So it kind of seems like this is a direct consequence of cutting the Medicare Advantage plans by $150 billion. Would I be correct in characterizing that as such?

Mr. HOLTZ-EAKIN. The insurers will be increasingly caught in the middle. They have obligations to limit cost sharing. They have obligations to provide benefits. There will be less money coming to them. Their only recourse will be to restrict whatever access to benefits they already had and limit the network so as to control costs.

Mr. BURGESS. So this is a story we are likely to hear repeated over time?

Mr. HOLTZ-EAKIN. Yes. I think what we have heard so far is just the leading edge of what will be a bigger problem.

Mr. BURGESS. So the American Association of Retired Persons has on its Web site myths about Medicare Advantage cuts, and one of the myths is that Medicare Advantage cuts would hurt seniors' ability to see their doctor. To quote the Web site: "If your current plan allows you to see a physician in the plan, nothing will change." Well, in light of this information, do you think that that is an accurate statement?

Mr. HOLTZ-EAKIN. No, I don't, and I think it will be increasingly inaccurate over time. To judge it by 2013 or 2014 is a mistake. It is the trajectory over the foreseeable future that concerns me the most.

Mr. BURGESS. So, you know, again, I just can't escape the notion that the entirety of the Affordable Care Act was sold to the American people on deception. The consequences of that deception are not becoming more evident every day. As a physician, I am particularly sensitive to the fact that patients are going to be excluded from their doctors. I wish the administration had been more honest about this, and again, I can't help but feel it was an active and purposeful deception.

Let me just ask you a question following up on some of the stuff that Chairman Dingell was asking. The cuts in Medicare Advantage, those cuts were taken out of Part A and Part B but not reinvested in Part A and Part B. Is that correct?

Mr. HOLTZ-EAKIN. No, those cuts will be used to pay for Medicaid expansions and insurance subsidies in the exchanges, and those monies will be gone at the moment they are spent. They will not be there for Medicare.

Mr. BURGESS. So I am not an economist. I am just a simple country doctor. But you are an economist, so how do you reconcile the fact that they are claiming that that is a savings that is increasing the solvency and longevity of Part A and Part B when the money was taken and then spent for some other activity?

Mr. HOLTZ-EAKIN. As the current CBO Director, Doug Elmendorf, has testified, and as any CBO Director would testify, that is an accounting fiction. There are no real resources in those trust funds to pay real bills from real providers for real patients.

Mr. BURGESS. I thank the Chair. I will yield back my time.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Well, good morning, and welcome to the panel, and I would like to thank the chairman and ranking member for holding this hearing on how the Affordable Care Act is improving and strengthening Medicare and Medicare Advantage.

According to a study that was done a couple of months ago, in my area of Florida, where we have a large percentage of our grandparents and parents who rely on Medicare, a number of statistics jumped out on the improved benefits in Medicare. One was what Mr. Dingell mentioned, the closing of the donut hole and the new discounts for prescription drugs. In the greater Tampa Bay area, over 77,000 of my neighbors now have major savings in their drug

costs under Medicare Part D due to the drug discounts. They have been worth over $100 million to the Medicare beneficiaries in the greater Tampa Bay area. That is very substantial, and that is due to the Affordable Care Act.

Also due to the Affordable Care Act, just in the greater Tampa Bay area, over 1 million seniors now have Medicare coverage that includes preventive services. They can go get the mammograms, the colonoscopies without copays or deductibles. That is a very important improvement to Medicare.

And Mr. Baker, I think you testified that these improvements apply in traditional Medicare and in Medicare Advantage. Is that correct?

Mr. BAKER. Yes, that is true. Yes, some Medicare Advantage plans did offer those preventive benefits, others did not. So what the ACA did—and of course traditional Medicare did not. So what the ACA did was make sure that those preventive benefits applied across the board in both traditional Medicare and in all Medicare Advantage plans as well.

Ms. CASTOR. Well, and I would like to take a page of how Mr. Dingell asks questions sometimes because my time is limited and I would like to get a yes or no answer.

Earlier this year, Republicans here in the House adopted a budget that proposed drastic changes to Medicare. The budget that was adopted would end traditional Medicare and Medicare Advantage and put in place a new system beginning in 2024. So if you are 55 or younger, this would really impact your future in Medicare. Rather than enroll in traditional Medicare or Medicare Advantage under the Republican budget, instead beneficiaries would receive a voucher. It would privatize Medicare. You would get a voucher, a coupon, and most analysts raised grave concerns that this would in essence very shift costs to our parents and grandparents that rely on Medicare. It really appears to break the promise that you will be able to live your retirement years in dignity and be safe from a catastrophic diagnosis.

I would like to know just yes or no from each of you, do you support that kind of drastic change to Medicare and Medicare Advantage? Yes or no.

Mr. HOLTZ-EAKIN. I do support that change, and the reason I do is, the CBO's report that came out this summer indicated it would save costs for beneficiaries and for the government, indicating it had broken the increase in cost.

Ms. CASTOR. So, yes, you support turning Medicare into a voucher?

Mr. HOLTZ-EAKIN. It bent the cost curve, and that is important.

Ms. CASTOR. And Mr. Baker?

Mr. BAKER. I do not support that proposal, and our organization does not support the proposal for the reasons that you indicated, that it would not, the value of that voucher would not keep up with healthcare costs and so more would come out of pocket of seniors and they would lose the health security that they currently have.

Ms. CASTOR. OK. Doctor?

Mr. MARGOLIS. I believe it is important for Congress to assure health security for seniors. My apolitical answer, which is very

hard to do here in Washington, I am sure, is to say this is about patients and patient care and that you should——

Ms. CASTOR. So yes or no? Turn Medicare into a voucher under the Republican budget?

Mr. MARGOLIS [continuing]. Support integrated care and coordinated care system development whether it is though that program or not.

Ms. CASTOR. Did you review the Republican budget proposal that privatizes——

Mr. MARGOLIS. No, ma'am, I did not review it.

Ms. CASTOR. OK. Ms. Gold?

Ms. GOLD. We don't generally take positions on legislation. We let you guys do that. But there are a number of technical questions and issues that have been raised about those plans, about the cost shifting that would happen to Medicare beneficiaries that are important questions to answer before any change to a very popular program were made.

Ms. CASTOR. OK. Mr. Kaplan, yes or no?

Mr. KAPLAN. I believe that the idea of using a voucher-type system, which is very akin to what is being done in the Medicare Advantage space already, is a good idea.

Ms. CASTOR. OK. That Republican Paul Ryan budget also included provisions to repeal the Affordable Care Act including the important reforms to Medicare—the closing of Medicare Part D coverage gap, known as the donut hole, the preventive services that we talked about earlier that are such a great benefit to many of my neighbors, those annual wellness exams, and important Medicare fraud prevention provisions.

Do you support the repeal of those provisions that have improved Medicare? We will start on this side. Mr. Kaplan, yes or no, because my time has run out.

Mr. KAPLAN. I can't give a wholesale answer.

Ms. CASTOR. Just yes or no real quick, because my time has run out.

Mr. KAPLAN. Yes or no. The answer——

Ms. CASTOR. You support repeal of those important reforms in Medicare that are included in the Republican budget, or not?

Mr. KAPLAN. I believe that are parts of ACA that should be repealed.

Ms. CASTOR. Ms. Gold?

Ms. GOLD. I think beneficiaries would be pretty upset if they were repealed.

Ms. CASTOR. Doctor?

Mr. MARGOLIS. I think protections for seniors are important.

Ms. CASTOR. Mr. Baker?

Mr. BAKER. Those protections need to be continued and be in place.

Mr. HOLTZ-EAKIN. I would answer differently, depending on the provision.

Ms. CASTOR. Thank you all very much.

Mr. PITTS. The Chair thanks the gentlelady. The Chair recognizes the gentleman, the chair emeritus from Texas, Mr. Barton, for 5 minutes for questions.

Mr. BARTON. Mr. Chairman, I arrived late and didn't get to hear their testimony, so I don't have questions. I appreciate the opportunity, though.

Mr. PITTS. The Chair now recognizes the gentlelady form Illinois, Ms. Schakowsky, 5 minutes for questions.

Ms. SCHAKOWSKY. I just wanted to make the point that I think Representative Castor was getting at too, just to remind my colleagues who are now complaining about cuts to Medicare in the Affordable Care Act, these were the same cuts that were included in the Ryan budget, but instead of strengthening Medicare, the Republicans wanted to give tax breaks to millionaires.

A couple of questions. The implication by my colleague, Dr. Burgess, was that changes that would eliminate and narrow networks are caused by the Affordable Care Act, and I am just wondering, Mr. Baker or Ms. Gold, in your research, I know with Part D it is important to check every year to make sure that the formulary is the same. With Medicare Advantage, aren't changes likely in the network or something prior to the Affordable Care Act as well?

Mr. BAKER. Yes. I think there is a lot of volatility in this private marketplace, in this private Medicare Advantage marketplace, as well as in the Part D marketplace. So every year we are very clear with beneficiaries that if they are in the Medicare Advantage plan, if they have a Part D plan, they need to check that coverage because the formularies, which are the list of covered drugs, change every year and provider networks change every year, and it is not just the plan that drives changes in provider networks; providers also decide to leave the network or to no longer be involved——

Ms. SCHAKOWSKY. So this is not new to——

Mr. BAKER. No, this is an inherent part of the Medicare Advantage plan that has been around since the Medicare Plus Choice program in the mid-1980s and even before. So this is an ongoing issue. This kind of instability, if you will, is inherent and it is a part of the risks of the Medicare Advantage plan that go along with some of the benefits that we have talked about as well.

Ms. SCHAKOWSKY. Thank you.

Also, Ms. Gold, Mr. Holtz-Eakin said something about sort of the precarious future of Medicare and funding problems. I wonder if you could talk about the effect on solvency that the Affordable Care Act has had on Medicare. Do you have that?

Ms. GOLD. I can try.

Ms. SCHAKOWSKY. OK. Or maybe Mr. Baker would have more——

Ms. GOLD. Yes, maybe. Go ahead.

Mr. BAKER. I think we noted earlier that two effects have occurred. One is that, as I was responding to Mr. Dingell's comment, that there is a longer period of solvency of the Part A trust fund, and to the extent that that has been looked at through the years as a bellwether for the health of the Medicare program, we are in one of the best places we have ever been. And secondly, something that has inured to the benefit of all people with Medicare is a stable Part B premium. Medicare costs are at historically low growth rates right now.

Ms. SCHAKOWSKY. And that is what you had said too, Ms. Gold, right, that rates are down?

Mr. BAKER. Right, and so everyone, all of the people with Medicare are seeing the benefits of that cost containment in the ACA and other cost containment efforts that have occurred both in private plans as well as in the government-run Medicare program.

Ms. SCHAKOWSKY. I also wanted to talk about low-income seniors. Medicare provides cost-sharing protections for low-income seniors through the Medicare Savings Program, or the MSP. I am wondering, if we are truly concerned about protections for low-income beneficiaries rather than paying more than Medicare to the Medicare Advantage plans, wouldn't it be better to invest additional resources in the Medicare Savings Program, improving outreach, enrollment and coverage, etc.?

Mr. BAKER. The short answer to that is yes. I mean, we are very concerned. Our biggest problem on our help line is folks that can't afford their coverage, whether they are in the original Medicare program or in the Medicare Advantage program, and Medicare savings programs, as you say, are programs that help lower income above Medicaid income levels but lower-income folks. Fifty percent of people with Medicare have incomes under $22,500 a year, and many of them are struggling to afford coverage as well as dental work and other things that aren't covered by Medicare. So it is strengthening those Medicare savings programs or subsidy programs, particularly if we are looking at the SGR and doing that simultaneously.

Ms. SCHAKOWSKY. Well, that I wanted to ask you about. We are certainly looking at the SGR. We would like to permanently repeal it, etc. But the qualified individual program which pays beneficiary Part B premiums is set to expire at the end of the year. So don't you think at the same time as we deal with the SGR, we ought to deal with that?

Mr. BAKER. I think it is imperative that that program be continued and it be continued to be dealt with with the SGR and continued and reauthorized, yes.

Ms. SCHAKOWSKY. Thank you very much. I yield back.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman.

Thanks for being here. Sorry I had to excuse myself during your testimony.

A couple points. One is, I, like myself, another member, a handful of staffers went down to make sure we were enrolled in our new healthcare plan because we couldn't get confirmation. Fortunately, I got confirmation but I am finding out like everybody else is, I have less coverage at higher cost, and the real concern is, and exhibited by my constituents on Medicare Advantage, we are going to see the same thing occur in Medicare Advantage. And so I think this is really a timely hearing because it is just like everything else in this new movement of health care is, everybody is going to get less coverage and higher costs no matter who you are or where you are in this country because of these reforms.

I was here in committee when Secretary Sebelius I guess 2 years ago affirmed the fact that they double-counted the $500 billion. You can just check the transcript. You can check her testimony. It took me 5 minutes to get it out of her. But in the end, she said we have

double-counted because we have this $500 billion of savings out of Medicare is going to go to Obamacare and of course, we are also strengthening Medicare by $500 billion. Having that as part of the record, how can we say Medicare is strengthened? Doug, can we make this argument that Medicare is now stronger than it ever has been?

Mr. HOLTZ-EAKIN. I don't believe that the Part A trust fund reveals anything about the futures solvency of Medicare. The plain facts on the ground are that in recent years, the gap between premiums and payroll taxes going in and spending going out for the Medicare program as a whole is $300 billion. That is a gaping cash flow deficit. We get 10,000 new beneficiaries every day. In the absence of genuine reforms that allow people to continue to get the care they need and deserve and do it at a slower cost growth, this program will fall under its own financial weight.

Mr. SHIMKUS. You know, my point is, numbers really matter, and again, for the Secretary to affirm $500 billion that is really not chump change in the big picture of healthcare costs, I am getting comments from constituents in my district who Medicare Advantage folks now their benefits are being reduced, they are losing access to their preferred physicians. This is under the current system right now. Again, back to Doug, my question is, how much worse can this get for my seniors who opt for Medicare Advantage?

Mr. HOLTZ-EAKIN. Again, if the strategy for controlling costs is this traditional one of just cutting provider reimbursements, whether it is doctors, hospitals, MA plans, it will backfire. We have seen again and again that that approach without reforms, without an approach that gives you the prevention, the coordination and the better care, Congress ends up having to put the money back in because you haven't solved the problem, and to not put the money back in is to deny seniors care. That is your choice.

Mr. SHIMKUS. And Bob, a lot of my seniors through Medicare Advantage have access to dialysis and the like, and I know you have a special focus in that arena. As networks shrink, especially in rural America, what happens to our options? What could happen to our options?

Mr. MARGOLIS. Well, I think you have heard that the cuts are not advisable in the future. I must say with all due respect to the committee, I think that the parity adjustment to get Medicare Advantage back to fee-for-service, which was enacted, is not the issue that should be focused on. What should be focused on, in my view, is that we are potentially reducing the payment for acuity of the sickest patients, which will incent insurers and others to avoid managing sick patients. Those are the ones that need coordination, that need population health, that need the access to good care, and that that is the issue that I would hope the committee will take a serious look at, because without that, while we may or may not have shrinking networks, and I think we will because even today we see news reports of United and others canceling thousands of doctors from the MA program, the real issue in my view as a physician and as someone who cares about seniors is that the sickest and most fragile patients that eat up all of the costs in health care are the ones that ought to be protected, and they ought to be protected by having appropriate acuity-adjusted payments to insurers

or directly to the physician groups that are managing them in a way that supports better outcomes, transparency, performance measurement, all of the star measures are positive. Let us support quality, performance and outcomes, and pay accordingly based on managing our sickest seniors.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Texas, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Chairman Pitts and Ranking Member Pallone for having this today, and our witnesses for taking the time to testify.

Medicare is critical to the well-being of our Nation's seniors and people with disabilities, many of whom have low to moderate incomes and complex healthcare needs.

My first question is, the Affordable Care Act did extend the life of Medicare by putting more money into Medicare, and I would like a yes or no answer to that. Did it actually extend the life of Medicare? And we will start with Mr. Holtz-Eakin.

Mr. HOLTZ-EAKIN. No.

Mr. GREEN. It didn't?

Mr. HOLTZ-EAKIN. No.

Mr. BAKER. Yes.

Mr. MARGOLIS. I have no knowledge of the facts.

Mr. GREEN. Thank you.

Ms. GOLD. I don't study the trust fund.

Mr. GREEN. OK.

Mr. KAPLAN. Same for me. I have not studied the trust fund.

Mr. GREEN. OK. Well, I think that we have many a difference of opinion but I think that is acknowledged, that it did extend the life of Medicare with the Affordable Care Act.

Mr. Baker, in your testimony you discussed changes to Medicare Advantage under the Affordable Care Act. The ACA included policies designed to make the Medicare Advantage system more efficient, reduce overpayments to bring plans more in line with traditional Medicare and enhance plan quality. Can you elaborate on some of these improvements in managed care under the Affordable Care Act?

Mr. BAKER. Well, as I said earlier, one of the improvements was making sure across the board that Medicare Advantage plans are covering preventive services as well as original Medicare. Another is the 85 percent Medical Loss Ratio so ensuring that 85 percent of every dollar, whether it is a consumer dollar or a government dollar, to these plans is going towards medical costs. Once again, the star ratings program and the out-of-pocket maximum, which I think have provided important financial protection to folks within the Medicare Advantage program, and the star ratings have made it easier, I think, for consumers to choose among plans. They do have, as I said, many choices in most markets, and the problem we frequently see is folks not being able to choose among plans so the star ratings have helped that a bit.

Mr. GREEN. Well, and I know from my area, we have a really great Medicare Advantage plan with Casey Seabolt in Houston that actually quit taking general Medicare because they wanted all their patients to go in. Of course, they are a great facility.

What recommendations would you have to further improve Medicare Advantage?

Mr. BAKER. Well, I think that once again we are very supportive of some of the good things that have come out of Medicare Advantage. We want to make sure that there are meaningful choices amongst plans, so really kind of standardizing plans to the extent that that is appropriate and possible. We would love to have more data on appeals within plans to see where there might be problems with a particular plan. We would like to make sure that there are better notices, so this issue that we have been talking about with regard to the slimming down of some of these networks, we do think that there could be more pinpointed notices sent to consumers in the fall. Many consumers find out about this from their doctor. It would be nice if they found out about it from their plan in September when they get their annual notice of change so that they can be ready in the open enrollment period, which begins on October 15th.

And finally, I think we need to make sure that the original Medicare program continues to be a strong program and kind of a base program for folks, and by that, we could help by increasing the availability of Medi-gap policies and open enrolled Medi-gap policies so people can switch back and forth between the programs as necessary.

Mr. GREEN. We have heard that Medicare Advantage would lead to wide changes in ACA and Medicare Advantage would lead to widespread of the Medicare Advantage market. From your perspective, has this been the case?

Mr. BAKER. We do not see widespread disruption at this point. We have seen some of these provider issues with providers leaving networks. Two things there: most of the consumers that have counseled have either chosen other plans that continue to have those providers in their network or have reverted to the original Medicare program where those providers are available to them.

Mr. GREEN. Ms. Gold, you have researched and written extensively about Medicare and scientific studies must meet certain established standards for the findings to be accepted including transparency of data methods, peer review and confidence levels to establish the validity of the findings. As a professional researcher, I am interested to hear your thoughts on Mr. Kaplan's study which lacked, in my opinion, the standards. I believe there are many questions that we need to have answered before we can definitely say that his results have great meaning.

Ms. Gold, would you agree that these are some of the questions that one would want to have answered before accepting the validity of the conclusions and the results of Mr. Kaplan's study?

Ms. GOLD. I do think, you know, usually when you have a study, they under peer review, the methods are laid out and you can look at it. I didn't have time to do a thorough review of the study but both I and a colleague looked at it quickly, and some of those details that you would want to see and which would ordinarily be there in a peer review paper were not there.

I think the most major part of the study that wasn't really talked about in the testimony was the sort of finding that over 1 year, so many people live longer if they were in MA, and I don't think any-

one really, whether they are pro or con MA or anything else, expects that that is a plausible finding. So I think there is some real questions about the risk adjustment and the selection of facts that are in that study. So, you know, I think there are some questions.

Mr. GREEN. I know I am out of time. Thank you, Mr. Chairman.

Mr. PITTS. Mr. Kaplan, do you want to take a moment to make a comment?

Mr. KAPLAN. Yes. So I appreciate the comments, and thank you for the question. We did have our studies reviewed. We actually were surprised by the findings, and that really caused us to pause because we were so shocked by some of the data that the data showed. We didn't have an agenda walking into this. We wanted to figure out what it would show.

So we did have it reviewed by a number of organizations, leading academic medical centers, because we wanted to challenge what we were saying. I understand that Ms. Gold did not review it or didn't have the time, and I respect that she didn't have the time to review it to be thorough, but we went through substantial reviews. What we said in this is that that one finding about mortality was the one that had greatest concern. That is why we wanted to go forward and do a longitudinal prospective study as opposed to just looking at it retrospectively.

But I would not throw out all the findings here. Again, we recognize that mortality was the one that is most concerning and no one wants to publish the fact that if you sign up for Medicare Advantage, you have a higher probability of living than if you sign up for Medicare fee-for-service. We did not want to publish that, but it was a finding we found.

Ms. GOLD. It wouldn't have been accepted in a journal because your detail wasn't there. I mean, I am not saying there may not be questions, but the detail was not in the report to know whether in fact that was legitimate or not, and it wouldn't have gotten through peer review.

Mr. KAPLAN. As I said, we did have it reviewed. We had it reviewed by leading academic medical centers. We did not submit it for peer review because we wanted to get it out to the market as quickly as possible.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Dr. Gingrey 5 minutes for questions.

Mr. GINGREY. Mr. Chairman, thank you very much.

I will have to say that Mathematica Policy Research might sound a little more highbrow than Boston Consulting Group, but if any of you know anything about Boston Consulting Group, you know it is one of the most outstanding companies in this country, and I do know a little bit about that.

Ms. Gold, in your testimony, you suggested—I am paraphrasing a little bit, but you suggested that the President fulfilled his promise to our seniors when he said if you like your healthcare plan, you can keep it, if you like your doctor, you can keep her. And you said it is called Medicare, suggesting, implying that if you got a notice from a Medicare Advantage plan that you had selected that you were no longer going to able to remain on the plan or they are going to have to get out of the business because of the $14 billion cut, 14 percent cut per year over 10 years, something like $300 bil-

lion, it was OK because you still had Medicare. You just diverted back into Medicare fee-for-service. I would suggest to you that that is pretty disingenuous to say if you like your plan, you can keep it, because you get kicked out of Medicare Advantage and you can go to Medicare fee-for-service if you can find a doctor.

It is clear that the Medicare Advantage program is under attack and that these beneficiaries are beginning to feel the effects of the over $300 billion in direct and indirect cuts included in Obamacare, and with plan cancellation notices already sent to, what, tens of thousands of our country's seniors, some of the most vulnerable citizens are faced with this uncertainty that I just talked about. Individuals are losing coverage that they are happy with and the doctors with which they are comfortable, and this is a tragedy. It is a tragedy of the law, a bill that was rushed through Congress without any serious debate, strictly partisan vote, is now directly impacting people's lives and their personal healthcare decisions.

Mr. Holtz-Eakin, let me ask you, would you please explain to the committee the reality for those potentially millions of people, seniors who lose coverage over the next few years, especially when it comes to a reduction in financial security and benefits?

Mr. HOLTZ-EAKIN. I think this is a very real possibility and something I am deeply concerned about, as you know. It is one thing to mandate that a Medicare Advantage plan cover certain benefits and offer those to seniors. It is another thing for that plan to be in existence so they can take advantage of it. And in the absence of a financial foundation, money trumps mandates. They won't have those choices, they won't have that care, and indeed, those who already have it, who made that choice, will see their plans taken away from them in violation of the promise.

Mr. GINGREY. Well, you know, the distinguished chairman emeritus Mr. Dingell—he is not still here, had to leave—but, you know, he made that statement in talking with Mr. Baker about the $14 billion that was saved out of the Medicare Advantage program, but of course, that $14 billion was not kept in Medicare, and really, he was only presenting one side of the balance sheet. Yes, $14 billion may have been spent on Medicare Advantage. Whether that was a little too much is open to question. But the savings that occurred to Medicare and we the taxpayer because of this Medicare Advantage program that has preventive care and all these features that traditional Medicare fee-for-service does not have, certainly not care coordination.

This benefit is used by seniors from all walks of life. It is especially prevalent for the seniors, and I think you said this earlier, Mr. Holtz-Eakin, with lower incomes. These cuts to benefits and coverage will affect lower-income seniors more directly than others. Is that correct?

Mr. HOLTZ-EAKIN. Yes, about 75 percent will be experienced by those making less than $32,000, ballpark.

Mr. GINGREY. And what will the loss of predictable annual cost mean to these populations?

Mr. HOLTZ-EAKIN. These are the most vulnerable of the seniors, and this has been a program that has given them not just the services in traditional fee-for-service but additional services and done it in a fashion of coordinated care and high-quality outcomes. It is

a loss of their personal choice but it is a loss from the perspective of having a viable Medicare program for the future.

Mr. GINGREY. Thank you, Mr. Holtz-Eakin. I appreciate your leadership on this issue.

Seniors are just now learning that the upheaval of our health care is not limited to the individual insurance market. That is the purpose of this hearing today. They now know that it will affect them as well, and seniors may lose benefits. We have heard testimony from Mr. Holtz-Eakin, from Dr. Margolis, from Mr. Kaplan, seniors may lose benefits, they may lose access to doctors, and be forced to pay more for their coverage, plain and simple. And I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentlelady from Virgin Islands, Dr. Christensen, 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and welcome to our panelists this morning.

From what I have read overall, Medicare beneficiaries should expect, in response to the question that we are answering today, and are already experiencing improvements from the Affordable Care Act, which have been enumerated by Chairman Dingell, my colleague, Ms. Castor, and others, and in part, those improvements, I think, have been made possible by the savings that came from equalizing the reimbursements of Medicare Advantage to those of traditional Medicare, and as a family physician and an old fee-for-service doc, I especially think that with the ACA reforms that the outcomes from both can be equally beneficial to the beneficiaries.

But I represent a territory, the U.S. Virgin Islands, and sometimes we have unique circumstances and suffer unintended consequences. So I want to ask a question on behalf of my colleague from Puerto Rico, and the question is to Bob Margolis. With the revised methodology under the ACA for paying Medicare Advantage plans using benchmarks based on fee-for-service data, should CMS coordinate the timing of the Medicare Advantage and fee-for-service processes? For example, in August of this year, CMS put out the 2014 fee-for-service inpatient rates that changed the Medicare disproportionate share payments to hospitals, but this was after the Medicare Advantage process for 2014 had closed in June, preventing the Medicare Advantage plans in Puerto Rico from recovering the substantially increased DSH payments they must now make to hospitals. Shouldn't CMS address this lack of internal coordination for 2014 and its harm to Puerto Rico's Medicare Advantage plans and their beneficiaries?

Mr. MARGOLIS. Thank you, Dr. Christensen. Clearly, I am not an expert on the rate setting but I would say that my understanding is that Medicare Advantage base rates are set based on the fee-for-service equivalency and that it makes very logical sense to me that we should have all of the built-in fee-for-service costs in the base rate when the Medicare Advantage rates are set. So I believe that would answer or direct an answer, and I think it is well known that CMS has for years not calculated the fact that SGR would probably be pushed out further so that they have not given credit to the SGR fix each year in setting the base rates for Medicare Ad-

vantage. So there are a variety of administrative issues I think related to how Medicare base rates are set.

Mrs. CHRISTENSEN. Thank you. I hope that answers Mr. Pierluisi's question.

Ms. Gold, I want to ask a question. We have heard a lot about the ACA causing spikes in premiums. While some plans have increased costs on beneficiaries, isn't it true that overall average premiums paid by enrollees have declined since the Affordable Care Act was enacted? And could you elaborate a little more on the premium changes? Premiums are not the same across all plans. So what factors contribute to differences in premiums among plans?

So let me just add another part of this question because of time. Isn't it true that the more than 70 percent of beneficiaries who are in traditional Medicare are the ones subsidizing lower premiums for the people in Medicare Administrative?

Ms. GOLD. Taking your second question first, yes, it is true that all beneficiaries subsidize it, plus the taxpayers, I might add, because that covers it too.

In terms of premiums, there is a lot of reasons. Costs vary a lot across the country, and some areas of the country are more efficient than others and some providers are more efficient than others. Premiums have often differed because fee-for-service payments are different. In some areas of the country, providers are stronger and they are able to negotiate higher rates. So there is less money available for extra benefits. In some areas of the country, some plans decide to give it back in less cost sharing at point of service rather than lower the premiums. So there is a lot of reasons things differ.

And I should add, you know, this fight between doctors and health plans has a long history that goes back years, and it is attention. You are trying to get the most you can out of the system, and the best thing the policymakers can do, I think, and Congress is to set good standards and say we want to buy quality, we want to buy value, and to reinforce that. I think the stars do start to do that, and getting those rights and figuring out across both programs, both Medicare Advantage and Fred Fox, how to make care better for beneficiaries because I don't think that care is as good as it could be for Medicare beneficiaries no matter what you are in, and there is a lot of variation across plans in what they are doing, which is not even all their fault. A lot of it has to do with the providers in different areas and how willing they are to get together and how fragmented they are, and especially for beneficiaries who have chronic illness, they need providers who talk to each other, and that is hard to change, and the plans are dealing with that and we are dealing with that because otherwise the beneficiary gets caught with the bill and the costs go up.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questioning.

Mr. CASSIDY. Yes. Thank you. I thought I was a ways after.

Ms. Gold, you sound like an advocate for MA plans because you are the one who is saying that there should be greater coordination of care.

And I am going to go to you, Dr. Margolis, because as a doc speaking to a doc, I thought your testimony was most kind of about what the patient's experience is as opposed to what the economists might say.

But Ms. Gold, just to point out, when you say that premiums will be lower in 2014 relative to 2010, that is because the market is actually offering lower-cost premiums with higher deductibles or allowing people to take their choice and therefore they are choosing a lower cost. It is not a function of the—that is what it is a function of.

Ms. GOLD. No, I don't believe so. Partly, we don't have good data on the other kinds of cost sharing but I don't believe that there is evidence yet that that is why that has happened.

Mr. CASSIDY. Common sense would suggest that. I will just say that. Because when people are voting with their pocketbook, they typically vote for a lower-cost plan.

Ms. GOLD. Well——

Mr. CASSIDY. And I am sorry, I have limited time.

Dr. Margolis, we have a controversy here. We have a controversy between Mr. Kaplan and Ms. Gold that says that they are not sure that there is improved quality data with MA plans. Your testimony is excellent. My gosh, when you show that graph of MA plans versus fee-for-service and the readmission rate is so much lower, number of hospital days, etc., that is just proof of what you are describing as an increased model of coordinated care. Fair statement?

Mr. MARGOLIS. Well, thank you for that compliment, sir. I think that there are within the written testimony things that are very evident. First of all, I am a high promoter of transparency of quality results and payment related to quality, so I recognize the star program as a very good step forward.

I wish there was a similar program in fee-for-service Medicare so we would have some evidence of whether Medicare fee-for-service is creating——

Mr. CASSIDY. So let me emphasize, though, because I am a liver doctor, I take care of special needs patients like cirrhotics. You mentioned end-stage renal disease. That is where coordinated care is most important, and yet you describe the cuts that go to the special needs program, correct?

Mr. MARGOLIS. Yes, I think I have said several times, I think the greatest threat at the moment is if we cut through this risk adjustment rescaling the benefit of adjusting payment based on acuity, we unfortunately then start to incentivize what used to be called cherry picking, which is avoiding high-cost patients. That is a disaster for seniors, and as you can see in the written testimony, if you really manage the high-cost seniors with comprehensive care, with palliative care, with end-of-life care with all those kinds of integrated programs, you can make a dramatic reduction in utilization.

Mr. CASSIDY. Dr. Margolis, I am going to cut you off a second because you have made your point, and I believe it. I have been struck that Ms. Gold and Mr. Baker continue to say they have not yet seen the problems that we are predicting and yet this wonderful graph in your testimony shows that we are just on the leading edge of these cuts and that there is compounding cuts that go

through what you have in 2019 where there are dramatic cuts ultimately to MA plans will receive. Do I characterize your graph correctly?

Mr. MARGOLIS. Yes, sir. It is why I have said that unfortunately——

Mr. CASSIDY. Now, I am sorry, I just got a minute 30 left.

Now, you have been describing the dire things that could happen to these important programs like special needs plans based upon 2015, but if we just extrapolate that out, if we have Mr. Baker and Ms. Gold come back in 2019, at that point is it fair to say that more likely than not they will be able to say at this point we have seen a negative impact of the cumulative effect of these cuts upon patient care?

Mr. MARGOLIS. I believe that is an accurate statement.

Mr. CASSIDY. Yes, so do I. Just as a doc who is going to go home and talk to a woman who is losing her MA plan and she is a diabetic, and she has had this wraparound service that has been able to help her so tremendously.

Mr. Holtz-Eakin, can you just lay to rest this myth that the ACA actually prolonged the life of the Medicare trust fund?

Mr. HOLTZ-EAKIN. As I said, there are no real resources in that trust fund. There is no way to pay a Medicare doctor's bill out of that trust fund. All the money that flows into it flows right out. The Treasury has spent every dime of it, and it is gone.

Mr. CASSIDY. And so when Mr. Dingell or Mr. Green suggest that we have actually prolonged the life through the ACA and you flatly say no, with your credentials, you just totally dispute that?

Mr. HOLTZ-EAKIN. I have testified numerous times as CBO Director and in the years since about the fiction of government trust funds actually being able to pay any bills, and it is just a fiction.

Mr. CASSIDY. I yield back. Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman, Mr. Sarbanes, for 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman. I appreciate the testimony of the panel.

Congressman Gingrey said something earlier, which I wanted to respond to. He said that seniors are now learning that the ACA is going to cause them harm. I don't think seniors are learning that. I think seniors are being told that by fear-mongering members of the other party who don't like the ACA, and I think that if seniors look carefully at their experience over the last couple of years, a period in which the positive impact of the ACA has begun to be felt, they will conclude that in fact the ACA is benefiting them. You look at the closing of the donut hole, you look at the new coverage of certain kinds of preventive care services, screening and other care services, annual wellness visits where copayments have been eliminated, you look at the incentive structures that have been put in place to help improve management of care and chronic conditions in a more sensible way within the traditional Medicare fee-for-service context as well as obviously within the MA context, there is just item after item of improvements which are there because of the Affordable Care Act, which are making the Medicare plan and Medicare coverage more robust for our seniors. So it is

just wrong to suggest that this is going to be harmful to the senior population.

In a sense, this hearing is titled "What beneficiaries should expect under the President's healthcare plan, Medicare Advantage," and I think they can expect good things. Everybody here generally is saying good things about the Medicare Advantage program. That is not the dispute we have. It is whether the Affordable Care Act is having a negative impact on what 29 percent of Medicare beneficiaries have access to or a positive impact. So when Mr. Baker and Ms. Gold say good things about the Medicare Advantage program, which they have, that is not somehow a contradiction on the other statements and testimony they are offering here. I think it is very consistent. It is just that you believe, in contrast to the other witnesses here, that the Affordable Care Act is actually strengthening and improving Medicare Advantage.

My understanding, Mr. Baker, is that the premium that was offered initially to Medicare Advantage plans, which is, I think, 114 percent against what the fee-for-service rate is, was done because the government wanted to incentivize the market and the private health insurance industry to come in and innovate and was successful in doing that. If you have 29 percent of beneficiaries that are now in those plans, it shows that that has happened. But along the way, because of good, rigorous analysis, we discovered that that premium was no longer justified, and in fact was going to some things that really ended up being a waste from the standpoint of the Medicare program. Can you just speak—I have used up most of my time here—but can you just talk again about two or three of the things that you think the Affordable Care Act has done to improve the Medicare Advantage program, which I think all of us want to see remain strong?

Mr. BAKER. I think, you know, three main things. One is the Medical Loss Ratio making sure most of the money that goes to—85 percent goes to medical care. I think, two, closure of the donut hole and the addition of preventive care services. I would also add, and I haven't talked about this before, but the Affordable Care Act does set up a program to enhance coordinated care in the fee-for-service traditional Medicare program through accountable care organizations and through other mechanisms as well as, I think, strengthen Medicare Advantage-like programs in many States that are partnering with the Federal Government with regard to coordinated care for dual eligibles, people eligible for both Medicaid and Medicare, and that is an ACA-generated program that does have some promise. It needs to be monitored but it looks like it has some promise.

Mr. SARBANES. Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you very much, Mr. Chairman.

I want to highlight a real-life example. My 83-year-old mother reports that her rates have risen for Medicare Advantage plan. In order for her to keep the policy that she has and likes, she is now paying higher rates. When Secretary Sebelius was here in April, she claimed Medicare Advantage rates were decreasing nationwide. So I did a survey in my district, and we found that more had rates

going up, not a huge amount. As Mr. Baker testified, the biggest group, or a bigger group, was those who stayed about the same. There were a couple of folks who reported that their rates had gone down.

I am just wondering, Mr. Holtz-Eakin, is this the case from your perspective nationwide that the Medicare Advantage rates are going down, as Secretary Sebelius testified earlier this year?

Mr. HOLTZ-EAKIN. We can get back to you with the data but I don't think those are the facts, but I would emphasize that there are big differences across counties, regions, States in the United States.

Mr. GRIFFITH. And let me go to that point because I had some curiosity as to whether that was one of the reasons was that I represent a very rural district where it takes hours sometimes to get to the nearest hospital, depending on where you are located, particularly since as a result of Obamacare and the cuts to Medicare we lost a hospital in one of my most rural counties a few months back. That was two of their top three reasons for why they were closing the hospital. Do you find that that is more likely to be a problem in rural areas where the rates are going up as opposed to more urban areas?

Mr. HOLTZ-EAKIN. Well, it is much harder to, you know, narrow networks, which is one of the ways to control costs in a rural setting because you don't have many choices, so they don't have the option to do that.

Mr. GRIFFITH. Yes, and in that particular county, they had one choice and now they have to drive a fairly—depending on what part of the county you live in, a fairly good distance to get to the next choice where they also only have one choice depending on what direction they go in. I do appreciate that.

Dr. Margolis, I ask you a rural question to in that you were talking about the health care and Dr. Cassidy, who I respect very much, showed the chart from your testimony and how the cuts are coming, and you indicated earlier in your testimony that is going to limit access for some folks. Is that going to be far more worse in the rural districts like mine?

Mr. MARGOLIS. I think that it is predictable that cuts will affect rural areas where there are fewer choices rather than the urban areas where there is more competition but I can't say that I have evidence to support that.

Mr. GRIFFITH. But common sense would lead us to that conclusion, would it not?

Mr. MARGOLIS. Yes.

Mr. GRIFFITH. Ms. Gold, do you want to disagree?

Ms. GOLD. Yes, because the ACA has the lowest payment counties actually benefiting. In some of the rural counties, they are going to continue to have 115 percent of fee-for-service. So I don't think it is payment in rural areas. I agree, there is a lot of problems in rural areas with managed care and getting it set up but I don't think it is the payment changes per se that are causing the problem.

Mr. GRIFFITH. So you would disagree with the folks who just had to close the hospital in Lee County, Virginia, and you would tell them that were mistaken in looking at their numbers?

Ms. GOLD. No, I can say that they have a real problem but it is not the ACA.

Mr. GRIFFITH. Well, unfortunately, those were two of the three things that they listed as the problem. The other one was the war on coal, in essence, the downgrading of the economy in our region also responsible to this administration.

But the other two things they listed were the ACA and the cuts to Medicare, so two out of the top three have hurt my people, and obviously I am very concerned about it and now I think it is going to affect perhaps the elderly also disproportionately represented in the rural areas of my district.

Mr. Holtz-Eakin, in that regard, you indicated that we shouldn't be looking at these Medicare Advantage rates based on 2013 but we should be looking to the future. Can you explain that more fully?

Mr. HOLTZ-EAKIN. Well, I am concerned that the current experience has been amassed, as the Chair mentioned at the outset, by the demonstration program, the Medicare stars demonstration program, which I will just take this opportunity to say not all MA plans are uniformly wonderful. It is a good idea to have a stars program to rate them. The demonstration program is not a good program. It does not reward good performance, and it needs to be reformed so that it actually does. But they plowed $8 billion in and disguised the genuine financial future of Medicare Advantage for the near term.

Mr. GRIFFITH. And I appreciate that.

And Mr. Chairman, with that, I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from New York, Mr. Engel, 5 minutes for questions.

Mr. ENGEL. Thank you, Mr. Chairman, and thank you, Mr. Pallone, for having this hearing today.

You know, I have been listening to my Republican colleagues lamenting the fact that healthcare costs, they say, are going up. They claim that the ACA is causing this to happen, although it is not true, and yet when we identify savings and cost, then they conversely say how terrible it. Well, you really just can't have it both ways.

In 2009, prior to the passage of the ACA, the rates paid to Medicare Advantage plans exceeded that of traditional Medicare by about 18 percent and the ACA required changes to Medicare Advantage payment rates to better align them with the costs associated with traditional Medicare, and these changes were estimated by the Congressional Budget office to save over $135 billion over 10 years. So you just really can't have it both ways. Every time we identify a way to save money, my colleagues on the other side of the aisle say look, this is so terrible, this is being cut, that is being cut, and then they claim that the ACA is causing costs to rise. I mean, you just can't have it both ways.

According to the 2010 Medicare Payment Advisory Commission report to Congress that in 2009 Medicare spent about $14 billion more to beneficiaries enrolled in the Medicare Advantage plans than it would have spent if they had stayed in traditional Medicare. So I want to go along the lines of the questions that Mr. Sarbanes did, and ask Ms. Gold, how did we get to the point where

we were paying so much for private insurers through Medicare Advantage to provide Medicare benefits and isn't it accurate that reforms in the ACA will help correct the overpayment problem with Medicare Advantage plans and play a role in extending Medicare solvency for all beneficiaries?

Ms. GOLD. Yes, I think it will have that effect.

Mr. ENGEL. I think it is also worth noting that all of the cuts to Medicare that were included in the ACA were also included in each of the Republican budget proposals for the last 3 years. So under Republican proposals, these cuts to Medicare Advantage will continue too.

On trust fund solvency, I want to mention the way we measure this solvency is by the Medicare trustees' report, and the trustees' report shows post-ACA solvency of Medicare is extended, and I think that is important to state as well.

Mr. Baker, I know that in the past there have been concerns about Medicare Advantage plans cherry picking and seeking to enroll the healthiest of seniors, leaving sicker beneficiaries enrolled in traditional Medicare. Have you seen evidence of this practice continuing, or what steps did the ACA take to try to stop this practice?

Mr. BAKER. Well, once again, I think the provisions in the ACA that require Medicare Advantage plans to have similar cost sharing for benefits that are typically used by sicker beneficiaries, and by that I mean renal dialysis, skilled nursing facility care and chemotherapy is one of the ways that those plans have become more attractive to those sicker beneficiaries and are something the plans can't use to kind of cherry-pick healthier beneficiaries over sicker beneficiaries.

I think what we see anecdotally, and it is borne out by some of the research, is that folks typically do join Medicare Advantage at a relatively younger and healthier age. As they age and become more chronically or severely ill, some do disenroll and enroll in traditional Medicare thinking that certain treatments, certain providers are more available in the original Medicare program. And so we do see that pattern emerge anecdotally in our work.

Mr. ENGEL. Thank you, Mr. Baker. Let me ask you this question on a different subject. In New York, we have about 2,100 physicians eliminated from United Health's Medicare Advantage provider network and is expected to impact about 8,000 of New York seniors. This was a business decision made by a private company and CMS is prohibited by law—I think it is important to say that—from interfering in the payment arrangements between private health insurance plans and healthcare providers. But I do hope that CMS will use the authority it has to ensure adequate provider networks are in place for all Medicare Advantage plans to help ensure beneficiaries have access to healthcare services.

So let me ask you, for seniors whose physicians are no longer a part of a specific Medicare Advantage network, what suggestions would you offer them? My understanding is that more than 90 percent of physicians in America are willing to accept new patients under the traditional Medicare program so is moving to traditional Medicare an option for them right now?

Mr. BAKER. Moving back to the original Medicare is an option for them right now or moving to another Medicare Advantage plan. It is our understanding that most of those physicians and most of the hospitals or other providers that have been dropped from United or other Medicare Advantage networks are in other Medicare Advantage networks or are, as you said, in the original Medicare program. So this happens every year to some extent and so our advice is consistently the same this year: look for another plan that has your provider in it or return to the original Medicare program if that is a better program for you overall and your provider is also involved in that program.

Mr. ENGEL. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman, and thank you for holding this very important hearing. I thank the panel for your testimony as well.

Mr. Kaplan, I was reviewing your report about how Medicare Advantage provides better outcomes and greater savings than traditional Medicare. Why does capitated MA produce such dramatically better results?

Mr. KAPLAN. I think there are probably two or maybe three things to take away that I think drive that, so one is the alignment of incentives, so in a capitated world, I think we all understand that the incentives are aligned between those who pay for the health care and those who provide the health care. So with that alignment, things tend to be more productive in how they perform.

The second point is that because of that alignment, what happens is that there is a huge investment in preventive care, so when they have the same goals and they are working towards the same, they are going to try to avoid these acute interventions to fix something that has gone dramatically wrong so they work with the member or the patient to try to manage them through it.

And the third point I really want to emphasize, which is what Dr. Margolis said, which is the issue around many of these members become very sick with time, age as well as where they are socioeconomically, and when they are, of the sickest portion or the 5 percent that drives 52 percent of the costs that require even greater intervention and greater coordination and so when these ideas of coordinating care and aligning incentives are very important, in all aspects of health care, it is extremely important towards the more chronically sick individuals.

Mr. BILIRAKIS. Thank you very much.

Mr. Holtz-Eakin, in the last Congress, about 40 percent of the seniors in my district had Medicare Advantage plans. So they love their plans, and it is very popular in my area. Of course, again, they like their plans. Back in 2010, CMS's Chief Actuary did a report on the impact of Obamacare to Medicare Advantage. He wrote, and I quote, "We estimate that in 2017"—I know you touched on this, but elaborate, please—"We estimate that in 2017 when the MA provisions will be fully phased in, enrollment in Medicare Advantage plans will be lower by about 50 percent." Does this track with your own analysis of these cuts?

Mr. HOLTZ-EAKIN. Absolutely. As you have heard today, Medicare Advantage is a high-quality program. It is very popular. In your district, it is even more popular than nationwide. The senior population is rising, 10,000 new beneficiaries every day. One would expect that if nothing else changed, you would see more enrollment, a lot more enrollment; we are going to see less. What has changed is the financial foundation. The cuts under MA are going to make it impossible for plans to survive, and those that survive will have to change their networks and their benefits and their cost sharing in ways that seniors will find undesirable. The net result is going to be less availability of Medicare Advantage.

Mr. BILIRAKIS. Thank you. Next question for you, sir. Some Democrats have been pushing the Accountable Care Organizations—ACOs—as a model for better care coordination and better cost savings. Doesn't Medicare Advantage promote the same concept with a proven track record of better outcomes and cost containment?

Mr. HOLTZ-EAKIN. MA has a track record, and it is by and large a high-quality track record, as I said earlier. Not every MA plan is created equal but it has a track record. ACOs are a concept at this point and unproven, and there is one big difference: seniors choose their MA plan, seniors are assigned to their ACO, and they have no choice, and that is the significant difference in the two concepts.

Mr. BILIRAKIS. Thank you very much. I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman, and thank you to our panel for being here on this issue.

Surveying the 2nd District of North Carolina, I have been hearing since the rollout of Obamacare that my constituents who are losing their Medicare Advantage are very, very concerned about this issue, as you can imagine, and it is showing in North Carolina that the cuts to benefits for seniors in Medicare Advantage are over $2,000 per beneficiary. Now that we are seeing this play out, the things that I am hearing from my constituents are that they are losing their access to care to their physicians, the cost is going up, and again, as you can imagine, they are very, very concerned about this issue.

To Mr. Holtz-Eakin, who is going to be most affected by these Medicare Advantage cuts? Which sector of population of our seniors? Because I keep hearing over and over again that it is helping our chronically ill patients who have this coverage and this is a better plan for them. Is that not who we are harming?

Mr. HOLTZ-EAKIN. This is a better plan for those with multiple chronic diseases in particular that need carefully coordinated care. They are typically lower income. There are typically more minority participants in MA. That is the population that will be affected, no question about it.

Mrs. ELLMERS. Now, can you identify some of the actual tangible benefits? I know you talked about coordination of care and items

like that. Are there any more specifics that we can hear so that we all have a better understanding of what we are actually losing?

Mr. HOLTZ-EAKIN. I will cede to the greater wisdom of Mr. Margolis and let him go first.

Mrs. ELLMERS. Dr. Margolis, would you—and I actually have another question for you, Dr. Margolis, on that issue. You know, you had identified quite correctly that we really need to be talking about taking care of those patients who are at the end of life, the ones who—we know those are where the dollars are really being spent. How do you feel about the IPAP, Independent Payment Advisory Board? That is going to come into play there, don't you believe?

Mr. MARGOLIS. Yes, ma'am, I certainly do not think that organizations like that should make decisions about individual patient care, on the one hand. And let me just say relative to that very sensitive topic: almost nobody wants to die in a hospital——

Mrs. ELLMERS. Thank you.

Mr. MARGOLIS [continuing]. If they have support at home, and with coordinated care, integrated programs, spiritual counseling, palliative care, pain management and 24-hour access to caregivers, you can avoid almost everybody having that unfortunate event in their family. That is a big opportunity, and let us support special needs programs, the dually eligible, and move towards Medicare Advantage much more aggressively.

Mrs. ELLMERS. I appreciate those comments, and that is exactly why I am as concerned about this issue as you are.

And Ms. Gold, I just have to ask you, yes or no, isn't that what you identified a few moments ago when you said that you thought coordination of care could be better served under another plan and under Affordable Care Act that that actually happens?

Ms. GOLD. I think there is a lot of problems with getting coordinated care.

Mrs. ELLMERS. But doesn't Medicare Advantage actually do that?

Ms. GOLD. No, only some plans do it. It has the potential——

Mrs. ELLMERS. No, I didn't——

Ms. GOLD [continuing]. But it doesn't have the reality——

Mrs. ELLMERS. Clarification here. I did not say that every Medicare Advantage plan, but I did say that Medicare Advantage plans offer these benefits. Is that yes or no?

Ms. GOLD. Yes.

Mrs. ELLMERS. Thank you. And just to finish out, we have got about a minute, and this question is actually to Mr. Holtz-Eakin and to Mr. Kaplan.

We have heard the bipartisan concerns here, and we want to make sure that we take care of our seniors, but we can see over and over again the Affordable Care Act is so negatively affecting our seniors with their Medicare Advantage plans. Just coming from a completely bipartisan perspective, what can we do now moving forward? What would you like to see in Medicare Advantage that we can move to that we can actually make a difference? Because we are going to have to make changes in Medicare, yes, and I would like to know from both of you what your thoughts are on what we need to do in Medicare so that we can make it better for our seniors.

Mr. HOLTZ-EAKIN. Well, I think it is very important that we have a sustainable social safety net for our seniors. Medicare needs to be a different program in the future both financially and because the care that seniors need is different than when Medicare was founded. Medicare Advantage is a great steppingstone to that future. It is not the end but it is a great steppingstone. It needs to be preserved, not wither on the vine in the next 5 years.

Mrs. ELLMERS. But we need that financial backing.

Mr. HOLTZ-EAKIN. And the near-term thing would be this risk adjustment issue that Dr. Margolis has mentioned. That is a very serious concern in terms of the funding.

Mrs. ELLMERS. Wonderful. And Mr. Kaplan, very quickly, if you can add to that.

Mr. KAPLAN. My simple answer is that this public-private partnership has been very successful and therefore, in my mind, we should invest in that and make that better as opposed to cutting it back.

Mrs. ELLMERS. Thank you so much. Thank you to all of you, and thank you to the chairman. I went over my time, so thank you for allowing me to do so.

Mr. PITTS. The Chair thanks the gentlelady. That concludes our first round of questions. We will go to one follow-up per side, and Dr. Burgess will begin with 5 minutes of follow-up.

Mr. BURGESS. Dr. Holtz-Eakin, I just want to follow up on some stuff we were talking about earlier in the first round. It appears in Washington today there is a crisis in confidence. The President has sold the Affordable Care Act on just a raft of false promises. You can keep your plan—false. You can keep your doctor—false. These are broken promises and these in fact are the opportunity costs that Americans are paying for the Affordable Care Act.

There was a promise made to seniors as well. The promise was that we are going to use your Medicare dollars as a piggy bank to fund the Affordable Care Act, and in doing that, we will improve Medicare and allow seniors to keep their doctors if they liked. So do you have an opinion as to whether or not this is yet another broken promise?

Mr. HOLTZ-EAKIN. It is.

Mr. BURGESS. And is it fixable?

Mr. HOLTZ-EAKIN. It is fixable in Medicare Advantage. I don't believe fee-for-service Medicare is fixable, it is the problem, so the focus should be on fixing Medicare Advantage in the ways that we described earlier, and——

Mr. BURGESS. But——

Mr. HOLTZ-EAKIN [continuing]. Promises are just that: they are promises. They are, you know, if you like your individual policy, you can keep it, but the regulations and the funding are at odds with the promise. The promise can't be held true.

Mr. BURGESS. So fixing it would involve alteration in the funding?

Mr. HOLTZ-EAKIN. Absolutely.

Mr. BURGESS. And at present, do you see any way or any mechanism by which that could happen? Is there anything to give you optimism that that funding in fact could be restored?

Mr. HOLTZ-EAKIN. Under current law, it won't happen. We need to change.

Mr. BURGESS. Let me ask you this. I wasn't here in 1988 and 1989. I don't know if you were involved.

Mr. HOLTZ-EAKIN. I am old, yes.

Mr. BURGESS. But there was a—Dan Rostenkowski, the Democrat chairman of the Ways and Mean Committee, put forward a catastrophic care program. He was very proud of it. It passed the Congress, a bipartisan vote, as I recall. They went home all very satisfied with what they had done. And then something odd happened. People rejected the law that was passed, and they rejected it largely because in a similar way, it sort of moving funding around in a way that seniors thought would be deleterious to their well-being. So then do you remember what happened the spring after that?

Mr. HOLTZ-EAKIN. After they got the bill and after they chased him with the umbrellas, they repealed the law.

Mr. BURGESS. So there is a mechanism by which this problem could be fixed also if we follow the 1989 repeal as precedent?

Mr. HOLTZ-EAKIN. There is no question this is fixable. It requires the Congress to act and the President to sign.

Mr. BURGESS. And it may require the people with umbrellas chasing the chairman of the Ways and Means Committee down the street.

Mr. HOLTZ-EAKIN. No comment.

Mr. BURGESS. No comment.

You know, I do have to just address the issue or ask, I mean, here we have all these experts in front of us. We get reports that the cost in Medicare has come down. In fact, we are going to get by the end of this week, I think the Congressional Budget Office is going to give us a projection on the proposed cut in the Sustainable Growth Rate formula, which is likely to be less than what everyone was anticipating. So that is good news. It may improve the score for repealing it.

A lot of opinions out there as to why this cost reduction is occurring. Of course, the administration in USA Today 2 weeks ago wanted to take credit for it and say it is all the Affordable Care Act. I don't know that is has really had time. Certainly the recession is playing a role but I don't know if that is the entirety of it. We are here just literally just 10 years passed the signing of the Medicare Modernization Act with the provision of Medicare Advantage and the Medicare prescription drug benefit, and if we really do believe that it is better to a stitch in time saves nine and it is better to treat early before a disease gets well established, perhaps we are seeing some benefit from passing the Medicare Modernization Act. Do any of you have an opinion as to whether or not that may be playing a role in these lowered costs? Yes, sir.

Mr. HOLTZ-EAKIN. I don't know how much of the current slowdown in health spending growth we can attribute to prescription drug therapies but we know the CBO and others have found that the Part D program has reduced costs elsewhere in Medicare, and that has been an important part of the change in the cost structure of Medicare. It has also been an important part of the structure of the entitlement. The Part D program which will have its 10th anni-

versary on Sunday is probably our most successful entitlement, and we should try to model every reform we can as closely to that as possible.

Mr. BURGESS. And that was actually constructed to be more like insurance and less like entitlement, if I recall those discussions back in the midst of time 10 years ago.

I thank everyone on the panel. It has been very informative. I know it has been a long morning, and Mr. Chairman, I will yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member, Mr. Pallone, 5 minutes for follow-up.

Mr. PALLONE. Thank you, Mr. Chairman.

I just wanted to say—I am going to ask my question of Mr. Baker but I just wanted to say with regard to Mr. Holtz-Eakin's testimony with regard to ACOs, I just disagree. You know, with ACOs and traditional Medicare, seniors have the ultimate choice. I mean, they can see any provider they want. They are not locked in for a year like they are with an MA plan. That is just my opinion. When I heard you talk about ACOs, I just wanted to express my view, which is that they are not locked in. They can choose whoever they want with ACOs in a traditional Medicare plan.

Mr. Baker, I just wanted to ask you about how Medicare Advantage can be improved. I think all of us here today agree that the Medicare Advantage program is a crucial alternative to traditional Medicare, especially for individuals with complex healthcare needs. But in your opinion, based on your organization's work over the years in assisting Medicare beneficiaries, what recommendations do you have for how the Medicare Advantage program could be improved for beneficiaries?

Mr. BAKER. Of course. I mean, I think the promise of managed care when it was initially put forward in the 1980s and then mid-1990s, a big push was that it would actually save the Federal Government money and provide coordinated care and additional benefits to people with Medicare. I think we have talked a lot about the advantages of Medicare Advantage but some of that promise hasn't been met. As we have talked, some of the plans are better than others but overall the level of coordinated care does vary widely amongst plans. And so we think, you know, better monitoring and oversight by the Centers for Medicare and Medicaid Services to make sure that those promises are kept, once again, better information about appeals within those programs. We oversample for the complainers in my organization. People call us when they have problems, and consistently what we see in the Medicare Advantage plans are problems with access to care, with utilization management or other barriers put to a variety of care, and we work with physicians and the plans to ease those barriers for people with Medicare and Medicare Advantage.

So having that information publicly available about which plans and how they are really kind of setting up maybe unnecessary barriers to care would be helpful and enable people to not only compare benefits but also to compare how those benefits are administered by particular plans and making sure that people are choosing those plans that actually are fulfilling the promise that a lot of us have talked about with regard to coordinated care, and I think, you

know, once again, this idea of custom tailoring stars, if you will, the stars program, while it is good, needs to be better and that people really want to know when you are looking at your two cars in Consumer Reports, there is not only stars on the cars overall but also on engine performance and on brake performance and other kinds of performance measures. So we will get to a place where I think we can customize those stars even more, and that will also help folks choose between the programs.

I want to reiterate that I think the original Medicare program or the traditional Medicare, which we have had since 1965, is the bedrock. It is something that people continually know is there and go back to, and it has, you know, regardless of a lot of what we have said, if you look at over the last 30 years, Medicare, the traditional Medicare program, and private insurance have done about the same job curtailing costs, good or bad. And so I think there is a lot of improvement that can be made in the original Medicare but there is also a lot of improvement that could be made in Medicare Advantage as well.

Mr. PALLONE. I only have a minute left, but some people including you have suggested we should consider establishing a so-called Medicare Part E, which would supplement original Medicare without beneficiaries having to pay for the overhead and profits of private insurance plans, and it intrigues me. Could you just elaborate a little on how you would envision that would be structured or how it would be an improvement to the current Medicare structure? You have a minute.

Mr. BAKER. In a whole minute? I think the Commonwealth Fund and others have put together a more comprehensive proposal on what is called Part E Medicare, and basically what it would do is combine Part A, Part B, Part D, prescription drug and Medi-gap, Medicare supplemental, in a government-run program, and this would go toe to toe with Medicare Advantage and with the original Medicare program as it exists now. Once again, it is an alternative. It is something that would exist alongside, and it would allow more choice for consumers and could have a lot of these coordinated benefits and coordinated coverage that we have been talking about today.

So I think that it is something that I think would put together in one place government-run program that has all of these components that people with Medicare value and need and could save money.

Mr. PALLONE. Thank you so much. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. The Chair thanks all the witnesses for your testimony. This has been an excellent hearing, very informational.

The members may have follow-up questions. We will submit those to you in writing. We ask that you please respond promptly. I remind members that they have 10 business days to submit questions for the record, so they should submit their questions by the close of business on Wednesday, December 18.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:26 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Statement of Rep. Henry A. Waxman
Ranking Member, Committee on Energy and Commerce
Hearing on "Medicare Advantage: What Beneficiaries Should Expect Under the President's Health Care Plan"
Subcommittee on Health
December 4, 2013

I am pleased that we finally have the opportunity to discuss the ways that the Affordable Care Act both strengthened the Medicare Advantage program for beneficiaries and strengthened the Medicare Trust Fund for the future.

Medicare Advantage enrollment and choices remain strong and growing. Contrary to predictions of the naysayers when the Affordable Care Act was passed, enrollment has not plummeted. To the contrary, it has grown by 30 percent since 2011. Beneficiaries have on average 18 plan choices – which may even be too many, given that groups that counsel beneficiaries on plan options say the sheer number of choices is dizzying for their clients.

The Medicare Advantage program is fairly popular among seniors, with more than a quarter of all beneficiaries now enrolled in such plans across the country. The changes in the Affordable Care Act, along with additional changes made by CMS to simplify plan choices, strengthen out of pocket protections, and prevent discriminatory cost sharing have greatly improved the program.

Overpayments to plans have been documented for years by independent organizations like MedPAC, GAO, and even the Inspector General. Yet despite this evidence, plans are conveniently blaming the Affordable Care Act provisions for any increases in costs to patients or reductions in plan benefits or availability.

Let me be clear, the ACA reined in a program whose costs were excessive, put it on a more sustainable footing, and improved offerings for patients too. I would think any of my colleagues who want to increase efficiency and root out waste would support these provisions.

Medicare is an entitlement to care for beneficiaries, not an entitlement for a private industry to make profits. Market turnover, changes in benefits and cost sharing, restrictions to provider networks are all tools plans use to manage their bottom lines.

If it turns out that Congress is not comfortable with that, the way to address it is through rules that increase stability - standardizing benefits, providing better options for beneficiaries who wish to return to traditional Medicare, or stronger notice and access requirements - not by

returning to the days of overpayments that drained the Treasury and drove up Medicare spending increasing beneficiary premiums.

Some have even suggested we should consider establishing a Medicare Part E, a Medicare-offered plan that could give beneficiaries more bang for the buck, providing additional benefits without them having to pay for the overhead and profits of private insurance plans. We should look at that.

Like my colleagues, I support the Medicare Advantage program and believe that for some seniors it is a valuable option. Every year, beneficiaries are encouraged to review their Medicare choices to ensure their health needs are met, whether they pick a plan or choose traditional Medicare.

As stewards of Medicare, we do not have to pick one or the other. We have a responsibility to make sure that **all** of Medicare is robust and on sound footing. This means demanding efficiency in both new delivery models that are underway in fee for service and demanding efficiency in the Medicare Advantage program too. Likewise Medicare must hold all providers – whether it's a plan, physician, or hospital - accountable for their quality and outcomes. We cannot return to the pre-ACA days of fragmentation, lack of accountability, and overpayments.

I thank the Chairman for holding this hearing and look forward to the witnesses' testimony.

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